



Couples' management of lifestyle change
in health and after coronary heart disease:

A Foucauldian- Deleuzian approach

Author: Martine Robson

Supervisors:

Dr Sarah Riley

and Dr Elizabeth Gagen

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Abstract

Non-communicable diseases, such as coronary heart disease (CHD), are the leading cause of death globally, and their link to lifestyle behaviours has led to national and global investment in healthy-lifestyle promotion. Located within the logic of neoliberal governance, health promotion constructs healthy lifestyle as a matter of individual responsibility and choice. Critical research identifies the potential for judgement and blame through this individualistic construction, suggesting an alternative framework is needed. But there is a gap in critical health research that considers how dominant health discourses are negotiated by couples. In contrast, mainstream health psychology research identifies intimate relationships as important mediators of health benefits. But findings are inconclusive, and indicate that wider social factors may contribute to the complexity of couples' health behaviours.

Drawing these two literatures together, this thesis aimed to explore couples' management of individualistic and pervasive healthy lifestyle advice. In developing a theoretical framework that accounted for the complexity of couples' health behaviours, it also aimed to provide an affirmative alternative to the logic of blame. To meet these aims, people in long-term relationships were interviewed about lifestyle and lifestyle change, both in the absence of diagnosed illness (Study 1), and after a diagnosis with CHD (Study 2). Their talk was analysed using a novel poststructuralist theoretical framework that combined Foucauldian Discourse Analysis (FDA) with Deleuzian concepts of affect, assemblages, and time.

Study 1 was designed to identify key issues in participants' talk about healthy living within relationships and test the analytical framework. In individual semi-structured interviews with seven people (five women and two men), participants extended neoliberal discourses of individual health responsibility to encompass their partners. Within this joint endeavour there were three discourses: 'weight...is a relationship thing', in which participants' negotiated distinct but parallel discourses of appearance and health; 'risky relationships', in which they constructed healthy lifestyle as joint risk management; and 'drift back into comfortableness', which built an account of healthy lifestyle as fluid, effortful and short term.

The salience of health led to the exploration of how couples negotiate lifestyle advice in the context of illness. Study 2 was a substantial, longitudinal qualitative project with 22 people (nine couples and four men in long-term relationships who chose to participate alone), recruited within two weeks of a partner receiving a new diagnosis of CHD, and interviewed once a month for three months, creating a total of 37 interviews. Using FDA with Deleuzian concepts, three main discourses were identified: ‘Ideal health citizens, ideal partners’, in which couples’ negotiated conflicting norms of ideal coupledness and responsible health citizenship; ‘expert patients, expert partners’, where couples managed competing knowledges and ensuing power relations; and ‘multiple temporalities of lifestyle change’, where couples referred to multiple time-frames or durations of illness, recovery, and ageing which afforded acceptance, stoicism, and the assertion of values other than the narrow pursuit of health through healthy lifestyle.

The novel contributions of this thesis include the following: A reconceptualization of ‘technologies of the self’ meant that couples’ joint practices could be understood as work on both self and other to produce desired subject positions, and revealed that imperatives of health can transgress relationship norms. Far from always being in alignment, ideals of coupledness could compete and conflict with those of good health citizenship. The thesis also contributed a novel understanding of how couples’ co-construction of risk through multiple experiential and expert knowledges produced intricate power relations. Finally, this thesis developed the field with an original application of Deleuze’s notion of time to couples’ talk of multiple and fluid temporalities of illness, recovery, and health could work for or against engagement in lifestyle change. In health psychology literature, intimate relationships are assumed to be protective and supportive of health, but the thesis indicated that couples’ joint management of lifestyle increases complexity and therefore possibilities for both affirmative and negative experiences. The Foucauldian-Deleuzian approach successfully engaged with the complexity and dynamism of couples’ health negotiations, offering an affirmative and ethical perspective on couples’ management of lifestyle advice and change that has valuable implications for future research and practice.

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Chapter 1 Introduction

Couples generally experience better health and greater longevity than individuals who are not in long-term relationships (Holt-Lunstad, Smith, & Layton, 2010). However, this broad finding masks considerable variability in health advantages among couples. Men may benefit more than women (Kiecolt-Glaser & Newton, 2001; Markey, Markey, & Birch, 2001; Walker & Luszcz, 2009), and people in long-term relationships have concordances for ill-health as well as health. Individuals are more likely to smoke if a spouse does, for example (Jurj et al., 2006), and couples tend to have similar blood pressure and cholesterol levels, contributing to concordant risk profiles for coronary heart disease (Di Castelnuovo, Quacquarello, Donati, de Gaetano, & Lacoviello, 2009). The variability in couples' health benefits has been attributed to their shared living environment and lifestyles (Di Castelnuovo et al., 2009; Meyler, Stimpson, & Peek, 2007), and to differences in attachment styles (Pietromonaco, Uchino, & Schetter, 2013). Theories of social control propose that couples influence each other's lifestyle behaviours in positive and negative ways (Lewis and Butterfield, 2007; Tucker and Anders, 2001), while another branch of health and relationship research attributes differences in health outcomes to variations in relationship satisfaction and quality between couples (Robles, Slatcher, Trombello, & McGinn, 2014).

Ideal relationships are constructed as healthy in medical and health psychology literature, with variations in health benefit being attributed to relationship dysfunction. The assumption is that positive relationships are productive of desired health outcomes, and healthy behaviours are therefore indicative of a good relationship. But these assumptions can be problematic. Categorising relationships as positive or negative does not account for variability within as well as between relationships, and contributes to a wider discursive context which potentially stigmatises couples and elicits guilt and blame when illness occurs. The predictive power of relationship theories remains low, and little is certain about the mechanics of processes involved in these outcomes (Idler, Boulifard, & Contrada, 2012; Robles, Slatcher, Trombello, & McGinn, 2014). Later in this thesis, I will argue that these problems arise from the complexity of intimate relationships and the challenges of

accounting for the dynamics of social, interpersonal, and embodied factors in couples' health practices.

In health research that examines the dynamics and variability of couples' health practices, the context of contemporary health discourses represents an underexplored factor. Yet critical approaches identify two important current health discourses, healthism and neoliberalism that structure contemporary sense making around health practices, and which therefore also shape what couples say, think, and do in relation to their own and their partner's health. Crawford (1980) coined the term healthism for the intense focus on health by individuals and society, typified by a strong awareness of risk and the pursuit of health as morally and socially appropriate. Healthism emerged in late-modern Western societies in the context of neoliberalism, a powerful form of governance which emphasises autonomy and responsibility. Through neoliberalism and healthism, individuals are understood to be responsible for their own health, and expected to monitor and manage their behaviour to achieve an ideal state of wellbeing (Crawford, 2006; Evans & Riley, 2014). Neoliberal assumptions are evident in language relating to self-control, choice, agency, risk, and individualism in current health campaigns that focus on smoking cessation and the regulation of diet, weight and exercise for the prevention of 'lifestyle diseases' such as coronary heart disease (CHD) and type II diabetes (Bacon & Aphramor, 2014; Crawshaw, 2012; Lupton, 2014).

The implications of neoliberal health discourses can be problematic: positioning individuals as responsible for health also implies responsibility for ill-health (Willig, 2009, 2011). Such discourses can produce stigma for those who are designated as overweight in healthcare settings (Kink & Penney, 2010; Kirk et al., 2014), while health promotion that elicits fear of heart disease and positions people as responsible for their own ill-health can be experienced as stigmatising and disempowering (Puhl, Peterson, & Luedicke, 2013). Lifestyle changes relating to diet, exercise and smoking are usually recommended after a diagnosis of CHD, which have implications for partners as well as patients (Di Castelnuovo et al., 2009; Meyler, Stimpson, & Peek, 2007). If individualistic discourses of health shape the ways that people think, talk and act, there is further complexity for couples as they negotiate potentially negative consequences on their partner's as well as their own

behalf. Diet, exercise, smoking and alcohol consumption are often shared practices, and intimate partners, family, and friends can support but also undermine efforts to make lifestyle changes (Cole, Smith, Hart, & Cupples, 2013; MacLean, Hunt, Gray, Smillie, & Wyke, 2014). Stewart, Davidson, Meade, Hirth, and Makrides (2000) found that lifestyle changes could become sources of conflict for couples, and that partners struggle to manage advice and information. Stewart et al. (2000) identify a lack of support for partners in this process, despite recognition of the role of partners in recovery and lifestyle change.

To illustrate how discourses that locate responsibility for lifestyle disease with the individual are materialised in practice, below I present a reflection on my own experience of managing lifestyle change with a family member, and the paradoxes and dilemmas that arise for patients with lifestyle diseases and their carers. Using this story, I examine how the assumptions and characteristics of contemporary, mainstream health information, promotion, and advice produce contradictory and judgemental discourses of lifestyle and lifestyle diseases which structured my experience. I reached for critical approaches to understand the logic of culpability and blame that I describe below, and then explore how poststructuralism theorises the complex ways in which dominant health discourses in health promotion are taken up and resisted in individuals' and couples' health practices.

1.1 The Problem.

I was sitting next to my sister in her hospital bed as she was awaiting coronary artery bypass surgery. She was very young to need such surgery, and was in distress, not simply because of the unexpected and serious diagnosis that she had received. She said over and over, 'I did this to myself'. She thought her weight was to blame for her heart disease. Although it felt very wrong that the bitterness of self-blame should be added to the burden of her disease, I also did not doubt that heart disease is caused by lifestyle factors such as smoking, eating a high cholesterol diet, lack of exercise, and being overweight. However, I reminded her that she had a family history of early heart disease (her father had died aged 52), and that genetics must have played at least some role in her condition. I worried, though, that I was

offering false comfort and that I might be dissuading her from making the lifestyle changes that her doctors had told her she would need to make. I did not know what to say, caught in between compassion for her suffering and the logic of contemporary understandings of the causes of heart disease which positioned her as responsible for her own illness. Caring for her postoperatively, I struggled with more dilemmas. How could I cook meals that were healthy without reinforcing the notion that diet causes as well as cures heart disease, without feeling that I was forcing dietary change on her, changes it would be morally laden for her to resist?

Nursing my sister gave me experiential knowledge of the paradoxes of current, dominant understandings of health and disease. Analysing data from the first study of this thesis, I was reminded of this time in my life when my participants articulated concerns about their own and their partner's health and lifestyle. The dilemmas, negotiations, and emotions of even these relatively young and healthy people resonated with my experiences. Later, I spoke to cardiac rehabilitation nurses, who described struggling with how to talk to people about lifestyle change, and how to avoid being judgemental of, or even frustrated by, patients' apparent irrationality when they do not adhere to lifestyle change. Through these personal experiences, formal research with participants, and informal conversations with health professionals, I came to an understanding that resolving these dilemmas would not result from finding correct, definitive answers about how to encourage people to take up healthy lifestyle advice. Rather, I saw a profitable direction as coming from a questioning of the assumptions underlying messages of personal responsibility for health and ill-health, which required a reframing of my understanding of lifestyle disease and change.

Despite public health promotion of lifestyle change as simple and achievable, and assumptions that concern for each other's health is natural in intimate relationships, from my experiences it seemed that people face considerable complexity in the management of their own and their loved-ones' health. I was interested in the logic of blame inherent in talk about responsibility for healthy living, for example, and to the ways in which partners and health care professionals talk to those attempting to make lifestyle changes. The aims of this thesis were therefore to examine the ways that couples talk about managing health, healthy

living, and lifestyle change. I was interested not only in their engagement or non-engagement in healthy lifestyle, but in the ways that they negotiated wider social understandings of health and healthy living within the context of coupledom, and the ramifications of those understandings for their relationship and take up of lifestyle change. Given the potential for research to reproduce social discourses that may evoke blame or culpability (Law & Urry, 2004), I also aimed to develop a theoretical framework that could encompass the complexities and dynamism of couples' health interactions, conceptualising them in ways that avoided the potential for reductive or pejorative categorisations (Kirk et al., 2014).

This thesis offers a micro-social, qualitative approach to examining the complex dynamic nature of couples' health communication and interactions, as recommended by Idler et al., (2012), who highlight the limitations of quantitative measures and models to account for the complexity of dyadic health behaviours. I conducted two qualitative studies about how people in long-term relationships negotiate health and healthy lifestyle, discursively analysed using a poststructuralist approach. I argue that a critical, poststructuralist approach provides an ontological basis for conceptualising the dynamics involved in couples' health interactions, wider social determinants of health, health information and advice.

Rather than assuming universal, stable truths, post-structuralism is concerned with how identity and reality are fluid, dynamic, and produced within socio-historic contexts through social practices and language (Foucault, 1980). Foucault theorised the ways in which power is exercised diffusely through institutions such as medicine, and how it produces a range of subjectivities. In order to understand themselves as responsible health citizens who meet social norms and ideals of health and appearance, people engage in 'technologies of the self' - everyday practices on the self that to allow them to understand themselves as meeting (Foucault, 1988, p.18). Power relations also circulate between individuals, offering a framework for thinking about couples' affirmative and negative health interactions and influence attempts. Foucauldian discourse analysis (FDA) therefore offers an approach for considering couples' health-related practices in relation to wider social discourses (Willig, 2000, 2001).

The analytical framework for this thesis therefore starts with FDA. During the first, exploratory study of this thesis the process of doing the FDA involved developing large spreadsheets for each of the discourses I identified as I worked systematically through interview data. At the bottom of the spreadsheet, I started to collect a list of ‘moments’ in the talk that did not seem to fit within the developing analysis. Much of this talk related to embodied experiences, materiality, and emotions, such as too tight clothes, rolls of fat around a partner’s waist, sensations of chocolate and crisp eating or smoking, the push-pull of a cold, wet night and a warm sofa. Participants accounts accounts of gap between the promise and actuality of exercising and changing one’s diet were infused with vivid emotions of fear, hope, guilt, and joy. I discussed these fluid, material, affective, and embodied experiences articulated in my participants’ talk with my supervisor, who recommended I read Deleuze.

Although Foucault’s work directly links discourse to practice and materiality (Butler, 1993), it was fellow poststructuralist Gilles Deleuze’s development of a fuller metaphysics that encompasses human and non-human existence. The concepts in the work of Deleuze, and also his colleague Guattari, that seemed to offer directions for broadening the analysis to include the material, embodied, affective, and discursive (Deleuze & Guattari, 1987). Although I found their work very challenging, it also seemed to offer significant potential to address my concerns. For example, the way Deleuze & Guattari (1987) considered the individuals’ lived experience to be a ‘relational processes of affective activity operating interpersonally...in all its potential messiness and contradiction’ (Smith & Tucker, 2015, p.4). And, it was in reading *A Thousand Plateaus* (Deleuze & Guattari, 1987) that clarified their conceptualisation of rhizomatic processes and assemblages with their heterogeneous interconnecting dimensions, which I used to expand the ontological framework of this thesis. Drawing on this work, allowed me to conceptualise the interactions and experiences that exceeded or resisted capture within the discursive framework.

Deleuze’s notion of assemblages proposes that objects and constructs are not singular and stable, but rather fluid and multiple, composed of material dimensions (spaces, technologies, and bodies) as well as expressive dimensions (identities,

meaning, affects and desires) (Malins, 2004). Intimate relationships have material components such as shared spaces, wedding rings, and embodied experiences of sex and eating, for example, while their expressive dimension include legal rights, emotional ties, cultural expectations and ideals. Thinking of health and intimate relationships as dynamic assemblages rather than bounded concepts provided me with a framework for exploring the intersecting material and non-material multiplicities that constitute health and intimate relationships, allowing for a dynamic account of couples' health.

For this thesis I therefore developed a poststructuralist-informed methodology that drew on Foucauldian and Deleuzian concepts. I used a Foucauldian-informed discourse analysis to explore the ways in which intimate partners adopt and resist wider social and expert discourses and norms of both health and relationships in their management of lifestyle and lifestyle change. I also used Foucault's notion of technologies of the self, expanding it to encompass couples' health behaviour, as they work on their own but also their partners' bodies, lifestyles and health practices. My analysis also used Deleuze's notions of affect and assemblages, in order to map the ways in which the complex affective flows between discursive and non-discursive elements of assemblages of health and of intimate relationships can create affirmative possibilities, but also the potential for tension and conflict as couples negotiate lifestyle change. My results offer a potential framework for rethinking assumptions about lifestyle disease and couples' health practices.

1.2 Outline of the thesis:

Chapter 2:

In chapter 2, I take a critical approach to examining contemporary Western health discourses, which form the context in which health, lifestyle, and lifestyle diseases are understood, and the ramifications for those who are concerned with maintaining their health through lifestyle management and change, but also for intimate partners who share that lifestyle, or who support someone with or at risk of a lifestyle disease such as coronary heart disease. I consider the problem of how to talk to and co-manage lifestyle change in the context of neoliberal understandings of

health as achievable through engagement in a healthy lifestyle, and the implications of discourses of personal responsibility for health.

Chapter 3:

This chapter contains a review of health psychology literature in the area of couples and health in the context of CHD. I present four major theoretical approaches, including social support, interdependence and social control, attachment theory, and research that attributes health outcomes to relationship quality. I also include a brief review of qualitative research involving couples where a partner has CHD, and I discuss the contribution of relevant critical literature. The rationale for the studies and the research questions are based on the findings, limitations and gaps in this literature.

Chapter 4:

In this chapter, I set out the theoretical framework for the thesis, which is based on the philosophies of Michel Foucault, Gilles Deleuze and his collaborator, Félix Guattari. I discuss how Foucault's concepts of power and normalisation can be applied to health, and I also set out what we can gather of his conceptualisation of love. I describe some of the main concepts from Deleuze and Guattari's metaphysics, and consider how they can illuminate aspects of health and intimate relationships. I then discuss the ways in which Foucault and Deleuze's ideas and methods overlap, and how they may work in complementary ways to theorise the complexities of couple health interactions.

Chapter 5

The method for studies 1 and 2 are set out in chapter 5. I first describe the design, participants, procedure and ethical considerations for each study in turn, and then set out the elements of the method that were common to both studies, namely the quality criteria, reflexivity, and analytic strategies. I describe the steps of the FDA I conducted, and also the strategy I followed to apply Deleuzian concepts of affect and assemblage in order to map participants' affective transformations of utilitarian, risky discourses of health.

Chapter 6:

The first analysis chapter presents the findings from Study 1, 'Joint Technologies of the Self', I present the Foucauldian analysis through which I identified couples' overarching construction of health and healthy lifestyle as a joint endeavour. I present three main discourses in couples' construction of healthy lifestyle: 'Weight...is a relationship thing' which explores participants' negotiation of parallel discourses of appearance and health; healthy lifestyle as risk management; and 'Drift back into comfortableness: healthy lifestyle as fluid, effortful and short term'. Foucault's concept of normalisation was used to examine how ideals of health and those of intimate relationships may come into conflict, and how dominant discourses of risk are internalised on a partner as well as the participants' own behalf. I used Deleuze's concepts to map affective and affirmative transformations of dominant discourses of health and healthy lifestyle.

Chapter 7:

In the first analysis chapter from Study 2, I present the discourse of 'Ideal Health Citizens, Ideal Partners' and describe the different ways that couples negotiate the competing and sometimes conflicting norms of health and intimate relationships as they manage lifestyle change in the aftermath of a partner's diagnosis with CHD. I use FDA to examine how dominant discourses and norms are adopted and resisted in couples' health interactions, and turn to Deleuze's concepts of affect and assemblage to map participants' occasional affective transformations of those discourses.

Chapter 8:

In chapter 8, 'Expert Patients, Expert Partners', I explore the second major discourse identified in the FDA of is couples' co-construction of knowledge and risk in their management of lifestyle change. The different knowledges upon which they draw – expert, experiential, and affective – troubled traditional dichotomies between lay and expert knowledge in their construction of intricate 'lay epidemiologies', giving rise to power relations that circulate between partners as they negotiate different types of knowledge to legitimise their relative, and sometimes opposing,

positions and practices. Deleuze's notion of knowledge as always embodied and experiential, and his designation of knowledge and power as elements in assemblages of health and relationships illuminate the affirmative as well as potentially negative ramifications of couples' joint management of risk.

Chapter 9

In the final analysis chapter, 'Multiple Temporalities of Lifestyle Change', I used Deleuze and Bergson's theories of time to account for couples' constructions of multiple and fluid time frames of illness, recovery and health. These temporalities afforded multiple discourses and practices in relation to lifestyle, and also accounts for the vivid and fluid ways that participants brought past, present, and future selves into their negotiations of their own and their partner's health.

Chapter 10

In this chapter, I discuss my aims in relation to the novel findings in both studies. I consider how my findings relate to and develop existing literature, discuss the implications of my findings, and also reflect on the strengths and limitations of the studies. I set out some directions for future research, and provide a brief, final conclusion to the thesis.

Chapter 2 Background To The Study

Introduction.

The finding that couples generally experience better health and have greater longevity than those who are not in long-term relationships (Holt-Lunstad, Smith, & Layton, 2010) forms the background to this study. Couples' health benefits are not universal, however, and there are patterns of concordance for illness as well as health (Kiecolt-Glaser & Newton, 2001). A wide literature has explored and theorised couples' health behaviours and outcomes. Research associates the variability in health benefits for couples with differences in relationship and communication styles (Uchino, 2013), and theories of social control propose that couples' influence on each other's lifestyle behaviours account for improved health outcomes (Lewis & Butterfield, 2007; Tucker & Anders, 2001). However, the complexity and dynamism of interpersonal relationships mean that the predictive power of these theories remains low, a problem that the literature associates with both the use of simplistic models of relationships, and with a paucity of understanding about the mechanics of processes involved in these outcomes and little is certain about the mechanics of processes involved in these outcomes (Robles, 2014).

Contemporary national and global health promotion reflects alarm over increasing rates of obesity (WHO, 2015), and presents health as achievable for individuals through lifestyle change, with a major emphasis on weight loss through self-regulation of diet and exercise (Bacon & Aphramor, 2014; Lupton, 2014). The implications of such discourses can be problematic. Positioning individuals as responsible for health implies responsibility for ill-health too, especially for 'lifestyle diseases', such as CHD and, increasingly, some cancers (Willig, 2009; 2011). Lupton (2014) argues that the continual association with weight and illness constructs the fat body as unhealthy and as representing a burden on health-care services, and so is stigmatising and disempowering (Puhl, Peterson, & Luedicke, 2013), while failure to reach ideal states of health and appearance can induce self-criticism and blame (Kirk et al., 2010). Despite the fact that 63% of UK adults are married or cohabiting (ONS, 2011), health promotion is rarely contextualized within

interpersonal relationships (Gastaldo, 1997). If wider social discourses of health shape the ways that people think, talk and act, there is further complexity for couples as they negotiate potentially negative consequences of health information and advice on their partner's as well as their own behalf.

By interviewing couples with no diagnosed health problems, and those where a partner had been diagnosed with CHD, the aim of this thesis is to examine the ways that couples talk about and manage health, healthy living, and lifestyle change. I was interested not only in their engagement or non-engagement in healthy lifestyle, but in the ways that they negotiated understandings of health and healthy living within the context of coupledness, and the ramifications of those understandings of health and intimate relationships. The current intense focus on health and healthy lifestyle by medical, public health, government, commerce and the media forms the context for people managing both health and illness. Understandings of lifestyle as causative and preventative of disease permeate society through medical, public health, educational, media and commercial messages. In this chapter, I will explore the emergence and characteristics of these contemporary understandings of health and lifestyle. A consideration of limitations, contradictions, and implications of these discourses for individuals and for couples in their health practices and relationships will form the context for then examining current theories and research relating to couples' management of lifestyle and lifestyle disease.

2.1 Contemporary Understandings of Health.

Dominant understandings of health in Western societies are based on a positivist scientific tradition; shaped by sociopolitical and economic conditions; and centred on the individual as an agentic subject, capable of making decisions and choices that either protect or damage health (Armstrong, 1995; Sparke, 2016, Thirlaway & Upton, 2009). As I will trace below, concern with health has moved from the private sphere to the public, with the rise of public health and government involvement in the management of health risks, including contemporary concerns over obesity and lifestyle diseases.

Public health.

John Snow's discovery in 1845 that individual cases in an outbreak of cholera could be traced to a contaminated water pump marked the beginning of the discipline of epidemiology and of public health, as the British government first recognized and then began to enact population-level preventative health strategies (Mbali, 2002; Aiello & Larson, 2007). The World Health Organisation's (WHO) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946, p.100) conceptualised health as a stable state that can be achieved and maintained through the actions of individuals, but also governments and institutions (WHO, 1986, 2015). At the time that the WHO definition was developed, infectious diseases were the primary causes of morbidity and mortality worldwide. But with a decline in communicable and a rise in non-communicable, or so called 'lifestyle' diseases, public health also shifted from a concern with broader determinants of health, such as infection and sanitation, to a focus on individual health behaviour (Lupton, 1997, 2014).

Life expectancy has increased globally over the past five years (WHO, 2015), but this is paradoxically a time of extensive and proliferating concerns about health (Crawford, 2006). So-called lifestyle diseases, including CHD, stroke, type II diabetes, and some cancers, are now the leading cause of death in high and middle income countries, but rates are also rising in low income countries (WHO, 2015). These conditions are associated with smoking, insufficient exercise and a diet that is broadly characterized by excessive amounts of saturated fat, salt, and sugar and insufficient intake of fresh fruits and vegetables (Kushi et al., 2012). Modifications to lifestyle such as increasing exercise levels and eating a healthy diet are therefore promoted as a means that will lead to a reduction in population levels of mortality and morbidity (NICE, 2015). The emphasis on the modification of diet and exercise has led to a strong association between weight and health, which dominates understandings of healthy lifestyle and lifestyle advice, and which I will examine in more detail below

Lifestyle.

Non-communicable diseases include some cancers, cardiovascular diseases, respiratory diseases, and type II diabetes and are designated as ‘lifestyle disease’ because of their causal link with behaviours including ‘tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol’ (WHO, 2011, p.16). As deaths from infectious diseases fall globally, the WHO predicts rises in the numbers of cancer and cardiovascular deaths, with the biggest increases in low and middle income countries. The WHO’s early definition of lifestyle as ‘patterns of (behavioural) choices from the alternatives that are available to people according to their socio-economic circumstances and the ease with which they are able to choose certain ones over others’ (WHO, 1986, p.118) encompasses notions of choice, but also recognizes the role of socioeconomic forces that shape people’s diets and engagement in exercise. The WHO also acknowledges the potential for blame in the attribution of individual agency in lifestyle (Thirlaway & Upton, 2009), and emphasises the importance of policy, environment, community and health services as well as the development of personal skills that enable people to ‘exercise more control over their own health and over their environments, and to make choices conducive to health’ (WHO, 2015, n.p.).

Dominant understandings of lifestyle are reproduced in sites such as the NHS choices website (2016), which emphasises the link between diet and exercise behaviours and health, focuses upon weight as a marker and determinant of health, uses the calories in/energy out paradigm as the primary key to weight management, and assumes individuals are autonomous in their lifestyle choices. Notably, exercise is only recommended in relation to weight loss. Despite the emphasis from the WHO’s Ottawa Charter for Health Promotion (1986) on social and structural determinants of health, current, dominant understandings of lifestyle disease reflect Doyle’s (2001) definition of ‘diseases that trace mainly to imprudent living’ (p.30). These discourses contribute to a moral dimension to lifestyle advice and information and a problematisation of obesity as a visible sign of poor lifestyle choices, and a lack of appropriate concern for health (Lupton, 1995, 2014; Schorb, 2013), which I will discuss below.

Focus on obesity.

The doubling of obesity rates in the UK and globally in the past 25 years (WHO, 2015) has become a major target of government health promotion and information, medical research, commercial interests, and the media. The UK government expresses alarm over the morbidity and mortality associated with obesity, and the burden of costs to the National Health Service (UK Government Foresight Programme, 2007). Obesity is characterized as both a cause of disease and a disease in itself, and is currently defined by measurements using Body Mass Index (BMI). In 1997, the WHO standardized the BMI boundaries between categories of weight to their current internationally-accepted levels, resulting in a substantial increase in the category of overweight in the US (Kuczmarski & Flegal, 2000). A BMI of between 25-29.9 is designated as overweight, 30-34.9 is classified as obese, and over 35 as morbidly obese. A rapid, international increase in BMI over the last three decades has resulted in a perception of a pressing threat to the health not just for Western and high-income countries, but for low-income countries too (Schorb, 2013).

The attribution of obesity to lifestyle factors, including inappropriate diet and a lack of exercise (Prentice & Jebb, 1995; NHS, 2016), has reinforced an association between overweight and common diseases such as CHD, leading to a conflation of weight and health (Bacon & Aphramor, 2014). Weight loss is now advocated to improve and indicate general health and as a primary prevention strategy for lifestyle diseases (NICE, 2015). The establishment of weight as an indicator or proxy for health has contributed to understandings of overweight as incompatible with health (Lupton, 2014; Flegal, Groubard, & Williamson, & Gail 2005). In this way, weight has become highly visible. It is monitored and measured by health professionals, and people engage in a wide range of weight-management practices and purchases, from joining commercial weight loss programmes, exercising, and buying goods aimed at assisting weight loss (Malson, Riley, & Markula, 2008; Tischner & Malson, 2011).

Contemporary Western societies are intensely beauty, weight, and health focused (Bordo, 1993; Crawford, 1980, 2006), and discourses of health and beauty overlap in several ways. Health discourses often equate health with attractiveness.

For example, Big Fat Problem promised that ‘you will look good and feel great’ (2006, p.2) after losing weight, while evolutionary and contemporary discourses of love and intimacy construct appearance as related to health and fertility assessments, and key to attracting and selecting a partner (Buss, 2000). According to this logic, beauty becomes a proxy for health, a fitness marker, with a healthy lifestyle reflected in a slim fit body and attractive appearance.

Health and beauty are both constructed as a personal responsibility, and something that can be achieved through the actions of the individual, so are sites of intense surveillance by the self and other and pressure to conform to narrow ideals of appearance and behaviour (Evans & Riley, 2015; McRobbie, 2009; Stuart & Donaghue, 2011). Social and cultural norms are internalised, and the pleasure or distress that ensues from conforming or failing to conform affirms practices related to beauty and health as arising from individual agency and choice (Rose & Miller, 1992). Discourses of confidence and empowerment arising from work on the self suggest that people choose to engage in beauty- and health-related practices for their own personal growth and satisfaction, rather than to conform to cultural ideals (Gill, 2007; Evans, Riley, & Shankar, 2010). Discourses of healthy living focus intensely upon weight (e.g. Gard & Wright, 2005), and since weight is both a marker of and prerequisite for health and beauty, and fat is constructed as incompatible with both (Tischner, 2013), symbiotic health and beauty discourses converge in practices relating to weight and weight management.

The association between weight, lifestyle and health has become the predominant focus of health promotion campaigns, with obesity identified as a mediating link between lifestyle and diseases such as diabetes and heart disease, and as a cause of premature death and disability (Lupton, 2014). Health promotion forms the context for contemporary understandings of health and health behaviour which I will examine in the following section.

Health promotion.

Health promotion is disseminated through health-care professionals, educators, and most visibly, through mass marketing campaigns. Both the WHO and the Centre for Disease Control (CDC) recognise a social-ecological framework for

health promotion, a model which incorporates multilevel environmental, social, economic, governmental, legal and interpersonal influences on individuals' health and behaviour (Bronfenbrenner, 1977; CDC, 2016; WHO, 1986, 2015). But Golden and Earp (2012) conclude that most campaigns are still more likely to target individual behaviours and characteristics than social, policy, or institutional factors, and national and international social marketing campaigns, health promotion information, and advice commonly share individualistic approaches and assumptions (Lupton, 2014) which I will outline below.

The dominant model of behaviour change in health promotion is a social cognitive model, whereby individuals are informed of and understand the risks and benefits represented by certain behaviours, and are then empowered to change, either through this insight or through the influence on their risk perception of other social actors such as peers, teachers, or family members (Lindridge, MacAskill, Gnich, Eadie, & Holme, 2013). A further assumption is that individuals are responsible for making lifestyle decisions, having agency and choice in matters relating to their health (Crawshaw, 2012; Golden & Earp, 2012). Those choices are not independent, however, but are based on expert advice and scientific evidence, which is passed on through public health campaigns, advertising and other media as well as through contact with health care professionals (Lindridge et al., 2013).

Health promotion sometimes acknowledges that modern, free-market economies offer opportunities for over-consumption, but within this environment people are encouraged by social marketing campaigns to make responsible health choices, involving both consumption and regulation. Commercial partnerships and sponsorship are increasingly common in national and global health promotion campaigns (Cryder & Lowenstein, 2011; Moodley, 2013), which positions individuals as entrepreneurs, and the self as a project or enterprise

What constitutes health and a healthy lifestyle and the values relating to both are assumed to be universal. The taken-for-granted knowledge of health as achievable through adherence to a healthy lifestyle, combined with individual responsibility for health forms the basis for a moral framework. Both the individual and the state are held to benefit from engagement in health-enhancing behaviour, and

conversely, the logic of behaviour which detracts from health is morally laden, demonstrating irresponsibility towards the self and others (Lupton, 2014; Crawshaw, 2012). Two recent social marketing campaigns that have taken place in the UK, Change4Life and its predecessor in Wales, Big Fat Problem, illustrate some characteristics, assumptions, and implications of contemporary health promotion.

Change4Life and Big Fat Problem.

The current Change4life programme (Department of Health, 2011) is an example of social marketing, and is aimed at reducing obesity and improving health through individual lifestyle behaviour change with the slogan is ‘eat well, move more, live longer’. The accompanying website highlights the risks of certain behaviours, such as the consumption of high-sugar drinks, and behaviour change is encouraged through information about healthier choices and the benefits they confer. Change is recommended through ‘swapping’ rather than eliminating favourite foods, drinks and snacks, and giving ‘easy’ and ‘simple’ tips for healthier eating and exercising. The campaign is illustrated with a cartoon family, and although the animated figures are gender and ethnically indeterminate, ‘Mum’ is addressed as the person responsible for encouraging the children to restrict access to sugary drinks for example.

The health promotion guidance that preceded the current Change4life campaign, produced by the Welsh Assembly Government and the BBC, was called Big Fat Problem (BBC Wales), and also exemplifies some of the characteristics that Lupton (1997, 2014) and Crawshaw (2009) identify in obesity prevention and healthy lifestyle approaches. The advice booklet’s cover, distributed to GP practices around Wales, showed a bulging belly with straining shirt buttons. The link between obesity and health is clearly stated on the first page, which sets out a ‘sick list’ of diseases that obese people are at risk of developing, with heart disease at the top. The risks are underlined by the ‘grim statistic’ that obesity ‘can shave a massive nine years off your life’ (p.1). The cause of obesity is attributed to the consumption of calories in excess of the body’s energy needs, and the solution is in the hands of the individual. By eating well and engaging in a more active lifestyle, ‘you’ll soon shed that extra weight and you’ll look and feel great’ (p.5). The promise of benefits to

one's appearance conflates aesthetics and health, and contributes to the salience of weight as a marker for health, reinforcing fatness and fitness/attractiveness as mutually exclusive (Crawshaw, 2007; Gough & Flanders, 2009; Gough, Seymour-Smith, & Matthews, 2016)

In the Big Fat Problem booklet (BBC Wales, n.d.), achieving a healthy lifestyle is described as 'simple' involving 'small but permanent changes' (p.3). There is an emphasis on 'simple swaps' unhealthy foods for healthier alternatives such as 'an individual pot of chocolate trifle for a pot of low fat mousse' (p.14) and high sugar soda for diet drinks. The section on activity suggests 30 minutes of activity five times a week, again with an emphasis on the ease of incorporating small changes and swapping one foodstuff or activity for another, as in the suggestion, 'Don't chomp through a packet of crisps in front of another repeat on TV – go for a brisk walk around the block' (p.20). As on the Change4Life website, potential barriers of money and time to exercise are mentioned, but are also dismissed with suggestions of low cost or free activities, leaving 'no excuse' for not engaging in activities such as 'walking, housework, gardening, washing the car, shopping (walking there and carrying bags home)' (p.22).

Change4Life and Big Fat Problem illustrate the characteristics of contemporary health promotion and social marketing campaigns. There is an emphasis on weight as the major marker for health, and dietary change and exercise are primarily aimed at weight loss rather than being recommended for their independent health enhancing properties. The model of behaviour change is a cognitive one – by gaining understanding of the health risks of being overweight, which is an indicator of a poor diet and lack of exercise, the expectation is that people will be motivated to make changes to their lifestyle. But the approach has been criticised on several grounds. The effectiveness of mass marketing is difficult to measure (Cavill & Bauman, 2004), but there is a lack of clear evidence that social marketing campaigns or similar health advice bring about sustainable lifestyle change (Aphramor & Gingras, 2008; O'Key & Hugh-Jones, 2010). Lifestyle advice is mutable and sometimes contradictory. Fruit juice is included as a 'five-a-day' portion, for example, but is not recommended by dentists and dieticians because of its high sugar content, and Gough and Conner (2006) identify both cynicism with

and confusion arising from often conflicting government and media health dietary advice as barriers to men's engagement in healthy eating. The individualistic focus of health advice can fail to account for the influence of wider determinants of health, and the notion that people can easily control their lifestyle, weight, and health can be stigmatising to those who don't (Rice, 2007). Such critiques of health promotion have been informed by wider critical analysis of contemporary understandings of health as achievable through adherence to a healthy lifestyle, which challenge the taken-for-granted knowledge and assumptions of biomedicine and health promotion. Below I consider these alternative ways of looking at the complexities of people's health practices and interactions.

2.2 Critical Approaches.

National and global lifestyle advice focuses on and conflates weight and healthy living, and advocates weight loss, through diet and exercise as a means of reducing risk for lifestyle diseases such as CHD (e.g. NHS Choices, 2016; American Heart Association, 2016; WHO, 2016). Criticism of these assumptions has come from biomedical as well as critical psychological and sociological research, which investigate the assumptions, ramifications and implications of dominant understandings of health, illness and lifestyle, as I will examine in the following sections.

Biomedical critique.

A dominant 'calories in: energy out' paradigm of obesity was widely disseminated in research such as Prentice and Jebb's (1995) influential paper, '*Obesity in Britain: Gluttony or sloth?*', a perspective that is pervasive and deeply rooted in media and lay understandings of weight. Jou (2014) challenges this biological model in her mapping of the multiple and complex correlates of obesity. What emerges in Jou's (2014) account is an interplay between factors on the micro- and macro-level, including the ways that genetic and individual differences interact with environmental, sociocultural and historical factors to produce patterns in obesity which are discernible on a population level, but which do not model clear causality or predict variability at an individual level.

An ‘obesity paradox’ has been identified that calls into question the assumption that thinness equates with health. Weight and risk of illness and mortality is a ‘u’ shaped curve, with higher mortality at low and high extremes of BMI, with people in the overweight category (BMI of 25-30) actually having the lowest risk (Afzal, Tybjærg-Hansen, Jensen, & Nordestgaard, 2016; Flegal et al., 2005). Contrary to assumptions about the incremental risk of weight and CHD, adults with CHD in the overweight or mildly obese (BMI of 30-35) category have the best health outcomes (Lavie et al., 2014). The authors suggest that higher levels of fat may have protective effects against heart disease and provide metabolic reserves that patients can draw on, resulting in better outcomes in serious illness.

Despite concerns over an ‘obesity epidemic’ (WHO, 2015; Schorb, 2013), Afzal et al., (2016) report that the BMI associated with the lowest all-cause mortality has increased over the past 40 years from 23.7 to 27. Over the same time frame, the 30% increased mortality rate that was associated with a BMI of over 30 in the 1970s has disappeared. In the most recent cohort examined, there was no excess mortality for those with a BMI over 30. For older people, these effects are more marked, with higher BMI being associated with better survival (Lavie et al., 2014). These findings challenge the simple, causal relationship between weight and health that underpins health promotion messages, and studies indicating that weight can be protective of health challenges the promotion of weight loss and a low BMI as universally good for health (Bacon & Aphramor, 2014; Childers & Allison, 2010).

The identification of BMI as a risk factor for so called ‘lifestyle diseases’ infers a causal relationship between weight and health (Williams et al., 2015), while health promotion messages also reinforce weight as a powerful cause of disease. Yet this simplistic paradigm masks considerable complexity in the relationship between weight and lifestyle disease. A large, multi-country study ranked smoking, high blood pressure, high cholesterol and diabetes as the strongest predictors of CHD ahead of weight, diet and exercise. Furthermore, it found that while abdominal obesity was a significant predictor of heart disease, BMI was not (Yusuf et al., 2004). Despite these findings, weight and BMI dominate health information and advice as a risk factor for heart disease relative to less visible but more significant factors such as high blood pressure and cholesterol. The conflation of weight with

health may occur because factors such as diet and exercise can affect both weight and risk for heart disease, for example. Diet and exercise are independently associated with CHD (Malhotra, Noakes, & Phinney, 2015) and can also contribute to other risk factors such as high blood pressure, high cholesterol, and type II diabetes. But in the simplified paradigms of health promotion, these associations are constructed as direct causal relationships between weight and heart disease (Bacon & Aphramor, 2014).

Aphramor (2005) also interrogate the relationship between weight and health that is taken for granted in health promotion discourse. She considers the 'energy balance' paradigm to be reductive, contributing the ineffectiveness of weight-loss interventions that are based upon it. Bacon and Aphramor (2014) argue that the conflation of weight and health draws attention away from lifestyle factors, such as eating a diet high in fruit and vegetables, and physical activity. Both these factors become subordinate to the goal of losing weight, which is not linked as directly to the development of lifestyle diseases such as CHD. This view is supported by Malhotra et al. (2015), who criticise the current emphasis on exercise as a means of weight loss, rather than as a health-promoting activity in its own right. The authors also challenge the message that a healthy diet is less important if an individual is thin and fit. Sports drinks that contain high levels of sugar, for example, increase the risk of type II diabetes even in athletes, and the authors highlight the role of the food industry in perpetuating misunderstandings about what constitutes a healthy diet. Bacon and Aphramor (2014) affirm that an emphasis on obesity as a marker and cause of disease has the potential to pathologise weight while underestimating potential health problems in thin people.

The Health at Every Size (HEAS) approach was developed to counter what Aphramor (2005) sees as ineffective and misdirected health-promotion efforts aimed at weight loss. Recommendations to restrict calories and increase exercise have not been successful in achieving sustained weight loss (Fothergill et al., 2016), dieting may even be counter-productive (Pietiläinen, Saarni, Kaprio, & Rissanen, 2012), and there are paradoxes, such as alarm over the 'obesity epidemic' taking place against a background of increasing longevity and decreasing morbidity (Aphramor & Gingras, 2008; Gard & Wright, 2005; Schorb, 2013). In a consideration of the potential for

negative effects of mainstream public health information and promotion which will be considered later in this chapter, critical biomedical and clinical perspectives begin to overlap. Lupton (2014) and Aphramor (2005) both argue that the conflation of fat bodies with unhealthiness increases stigmatization, and that a focus upon slimness as an optimal state of health and appearance contributes to body dissatisfaction, eating difficulties, discrimination and abuse.

Critiques of a decontextualised approach to health promotion are gaining the attention of biomedicine and policy makers. The House of Commons Health Committee report (2015), for example, recommends that exercise should be promoted for its own health benefits rather than as part of a weight loss programme, and recognises that action is required at a broader social as well as individual level. The report even highlights the economic challenges to developing a coherent programme to support increases in exercise and activity at a population level, especially in times of austerity. While in the US, public discourses about individual responsibility reduce support for policies targeting wider social determinants of health, the importance of which is increasingly recognised by the medical community (Barry, Gollust, & Niederdeppe, 2012).

By challenging the assumptions of dominant models of health within biomedical and mainstream healthy psychology approaches, and drawing attention to adverse consequences which may affect particular groups, critical perspectives highlight health inequalities and the negative ramifications of mainstream health promotion messages about lifestyle, weight and health. In the following section, I present a poststructuralist critique of traditional, positivist biomedical and health psychology approaches to health and healthy living, and from this perspective, explore the implications of mainstream approaches to health behaviour.

Poststructural critique: Private to public health.

Foucault (2003) charted the shift in health from something that was previously private and personal into the public sphere as health practices and outcomes came under government scrutiny towards the end of the 19th Century. Foucault used the terms ‘biopolitics’ and ‘biopower’ for the ways in which personal or sociocultural experiences such as birth, death, and illness, began to be governed in

the sense that medical and government institutions gathered data, determined causes, implemented interventions, and calculated public costs with the aim of improving public health (Foucault, 2003, p. 243; Rose, 2001).

Government involvement in life, illness, health and death privileges expert knowledge, and regulates individuals through the subjectivities that such knowledge produces (Foucault, 2003). He characterised individuals as ‘docile’ bodies, which ‘may be subjected, used, transformed, and improved’ (1995, p.136) through the disciplinary forces of the state. Such bodies are produced not by direct injunctions or discipline, but by processes of normalisation and internalisation, so that people understand their management of weight and diet as a personal goal and as part of their development, improvement and transformation into a better self.

Critical approaches use Foucault’s ideas about biopower to identify the limitations of and power relations inherent in the discourses of traditional, mainstream health psychology and health promotion. The key concepts of governmentality, neoliberalism, and healthism illuminate the consequences for individuals of these wider discourses and understandings of health and healthy living.

Governmentality.

Foucault (2003) did not take a benign view of the emergence of state involvement in public health, which resulted in a medical establishment whose function, he stated, was to ‘coordinate medical care, centralise power, and normalise knowledge’ (p.244). Foucault rejected claims that health policy reacts to the biologically-based health needs of the population, arguing that government and medical institutions both construct and problematise health and health issues. Foucault’s argument was premised on his insight that knowledge is always socioculturally and historically contingent, fluid and contextualised rather than fixed and universal.

Government management of public health is similarly fluid and decentred. Biopolitics does not involve a single organised movement, with a clear hierarchy, but rather a proliferation of measurement, regulation and control that spread through

institutions such as education, medicine, sanitation and infection control, and accomplished the movement of matters of life and death from the private sphere to the public (Rose, 2001). Foucault (1995) used the term ‘governmentality’ for this diffuse and multiple form of power, which operates on a personal and societal level. Governmentality does not refer to an overarching interest or source of power, but refers to ‘ways of problematizing and acting on individual and collective conduct in the name of certain objectives which do not have the state as their origin or point of reference’ (Rabinow and Rose, 2006, p.200).

Foucault emphasised that power is creative, productive and affirmative as well as oppressive, and these dimensions are both visible in health. What makes power accepted is ‘that it doesn’t weigh on us only as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse’ (Foucault, 1980, p.119). These things are produced in relations between people, affecting their respective capacities, increasing or diminishing their powers of acting and being in the world. Medical discourses and interactions are not only repressive, as power shifts between doctors, nurses and patients in fluid ways. In her application of Foucault’s concepts of disciplinary power to her study of a cardiac rehabilitation clinic in the USA, for example, Wheatley (2005a, 2005b) reports that the regulatory procedures of the clinic were disrupted by patients’ resistance to organisation and surveillance, as their own desires and priorities are negotiated alongside the regime of the clinic; affirmative experiences of cardiac rehabilitation coexisted with its disciplinary and sometimes oppressive dimensions.

Public health has produced uncontested benefits, but critical perspectives also identify the capacity of biopower to establish and perpetuate inequality and social injustice through processes of subjugation, marginalization, and pathologisation of those who do not conform to societal and behavioural norms (Rose, 1999; Foucault, 1988; Crawford, 2006). The potential for harm of dominant health discourses necessitates careful exploration of the ramifications and implications of government aims and means to promote the health of its citizens, as the processes of normalisation, judgement, and observation are subtle.

Surveillance forms part of the disciplinary process in Foucault's conceptualisation of biopower, surveillance by diffuse nodes and modes of government, which is taken up by individuals and turned on the self and other:

Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost (Foucault, 1980, p.155).

Armstrong (1995) identifies the rise of 'surveillance medicine', characterised by observation, measurement and 'problematization of the normal' in relation to both physical and mental health, in order to extend a 'network of visibility' to encompass whole populations (p.395). Rather than binary categories of illness and health, a new continuum has been created by technologies of screening and risk identification to produce a state of affairs where 'everyone was normal yet no-one was truly healthy' (p.397). The state of precarity extended medical surveillance outside of hospital and medical settings and into the community and people's homes, as lifestyle behaviours, for example, are increasingly included in national and global policies, creating sub-populations of 'at risk' individuals, and risky practices and objects of surveillance (Farrimond, Saukko, Quereshi, & Evans, 2010; Petersen & Wilkinson, 2008).

Deleuze (1991b) conceptualises governmentality as a beam of light that illuminates particular targets of governance and control. Combining Deleuze and Foucault, measurements such as BMI, can be conceptualised as making individuals intelligible and visible, to themselves and others (Miller & Rose, 1996). The visibility and measurement of weight makes it open to surveillance and management by the state, commercial forces, and by individuals, illustrating the diffuse ways in which governmentality works. Governmentality is the means by which modern power is exercised through health discourses and institutions, and which are shaped in contemporary times by global neoliberalism.

Neoliberalism.

Neoliberalism is a late modern political philosophy characterised by support for a free market economy, and for deregulation and minimal government interference in that market. In pursuit of a reduced welfare state, neoliberalism emphasises individual responsibility and agency, and so encompasses the political, sociological, and personal which has resulted in its broad application across a variety of disciplines, and contributed to its multiple meanings (Venugopal, 2015). In this thesis, I use the term to signify what Venugopal calls ‘deep’ neoliberalism which conceptualises power as operating not as a single, easily identifiable, oppressive force, ‘but through a multiplicity of governing networks, nodes, and modes’ (p.170). Rose (1999) and Rose and Miller (1992) use this understanding of neoliberalism in their descriptions of de-centred, contextualised power relations in health institutions and practices, which then work in part through what Foucault (1988) termed ‘technologies of the self’ (p.18), whereby individuals engage in practices on the self in line with social norms and ideals.

The neoliberal concept of the person is of a rational, autonomous self, able to apply technologies of the self in pursuit of appropriate self-transformation. An important site for such work on the self is health (Crawshaw (2007)). In neoliberal societies, citizens are under pressure to take responsibility for their own health and well-being and to maintain a ‘socially appropriate and acceptable body form’ (Crawshaw, 2007, p.1607). Evans and Riley (2014) identify such technologies in ‘body work’, including management of diet and exercise, undertaken by individuals in pursuit of a transformative ideal shaped by social, governmental and commercial forces. So that, among the proliferation of interested parties, including charities, campaign and pressure groups, as well as health-related business, ‘the health-related aspirations and conduct of individuals is governed ‘at a distance’, by shaping the ways they understand and enact their own freedom’ (Rose, 2001, p.6).

Rose (2001) traces the roots of current biopolitics in health-valuing societies back to the hygienist and eugenics movements of the early 20th Century. Health was held to be indicative of physical fitness and superiority in Darwinian terms. This fitness was valued in the context of national defence and competitiveness. Rose

argues that although governments still organise health promotion at a national level, the ‘will to health’ is now economic and moral, with responsibility for achieving these obligations devolving upon individuals and families.

Rabinow and Rose (2006) consider how Foucault’s notion of biopower and biopolitics may be used to critically examine discourses relating to truths of health and life, the ‘strategies for intervention’ based upon the categorisations and understandings warranted by these discourses. In so doing, they consider the ‘modes of subjectification, through which individuals are brought to work on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole...’ (p.197). Contributing into these modes of subjectification is also a European history of social policies and engineering aimed at enabling people ‘to act economically in a highly competitive capitalist society’ (Schorb, 2013, p.5).

Neoliberalism, through its pervasiveness and subtle effects, has become the default and common sense way of understanding and experiencing the world in countries like the UK; economic arguments are common in medical and ethical debates, producing paradoxes and inconsistencies when it is combined with sociocultural and historically situated values (Sparke, 2016). For example, people are encouraged to manage their weight to protect the state from the burden of their health care costs, but this logic is invoked less often for other conditions, such as childbirth or cancer care. In this way, neoliberal discourses can be seen to both shape and be shaped by institutionalised stigma and discrimination.

Greco (2009) highlights a paradox that exists in health promotion, reflecting a parallel paradox of neoliberalism (Rose 1999), which is the obligation of freedom. Health promotion predicates choice and freedom, but some choices are not legitimate, so have to be guided by discourses of physical, moral and social risk, a risk borne by the individual. A similar contradiction can be seen in the competing forces of guidance and responsibility in patient-centred versus self-management discourses. There is a contradiction between patient choice and management which is however, not independent from expert information, guidance and advice (Mol,

2007). Patients are expected to be autonomous and self-managing, but only in ways that conform to normative understandings of health. Thus, understandings of health is a personal project, but one that is in line with cultural norms, has become a major characteristic of modern Western societies, involving individuals, governments and global businesses and institutions (Crawford, 1980, 2006).

Healthism.

Crawford (1980, 2006) describes the current intense government, medical, scientific, commercial and social focus upon health as 'healthism'. Healthism is characterized by a medicalization of everyday life and by a locating of responsibility for health problems and solutions with individuals rather than with wider social determinants, though individuals' health practices are guided by expert knowledge, medical institutions, and the state. The 'good citizen' is expected to gain and act upon health knowledge, constructing complex understandings of the causation and prevention of disease. Health becomes a site of identity formation, as 'in a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices...Through health, the modern self demonstrates his or her agency, the rational capacity to re-make self and world" (Crawford, 2006, p.402-3). Maintaining a positive health identity involves an understanding of lifestyle behaviours as representing a risk or benefit to health, and non-adherence to those behaviours opens an individual up to criticism or judgement. Carla Willig (2011) recounted that her diagnosis with cancer elicited questions about her lifestyle-related risks. Judgements about her past diet and exercise habits, and advice about lifestyle change positioned her illness as 'occasioned by the self' (Stacey, 1997, p.175, cited in Willig, 2011), a drawing of causal relationships that produces blame and guilt.

Within the context of healthism, Crawshaw (2007) observes that 'individuals are increasingly constructed as active consumers of health advice; as responsible citizens with an interest in, and a duty to maintain, their own well-being both to improve health and fight disease' (p.1607). Health promotion in neoliberal times is predicated upon a moral imperative for individuals to take responsibility for and manage their own health, especially in relation to 'lifestyle' diseases (Peterson &

Lupton, 1996; Lupton, 2014) as, paradoxically, the idealization of freedom and choice are constrained by the need for responsibility and self-governance. For example, people are not free to ‘choose’ to be overweight. Rather, being fat is attributed to a failure to diet and exercise appropriately and is constructed as pathological, signalling physical, psychological and moral dysfunction.

Crawford (2006) identifies an underlying paradox of healthism: the more one focuses upon health, the greater sense of jeopardy one experiences, leading to a spiral of anxiety and control. Illness is referred to in health promotion material and campaigns as a consequence of poor lifestyle choices, while the inevitability of degenerative aging processes and of death is not explored. Individuals must negotiate this threat perception in parallel with experiences and understandings of health as unpredictable and uncontrollable, producing intertwining narratives of responsibility and fatalism (Crossley, 2002), and accounting for orientations to health as both within and beyond control. Biomedicine and health promotion increasingly emphasise lifestyle as a cause of and cure for disease, and theories of regulation, control and surveillance can clearly be applied to visibilities such as weight, smoking, drinking and exercise. Both the salience of lifestyle advice, and its construction as a civic and personal responsibility, creates a moral dimension, the logic of which produces affective responses such as shame, guilt, or satisfaction depending on how well people are able to follow healthy living injunctions (Galvin, 2002; Hansen & Easthope, 2007).

Within this framework/healthism healthy lifestyles are predicated on the management of risk by rational agents, thus risk is a central feature in healthism, as discussed below. Risk is central to healthism since contemporary health promotion, information, and advice are predicated on a ‘rational’ model of human behaviour, whereby threats are perceived and avoided through the modification of risky behaviour, as I will consider below.

Risk.

Biopower is the series of mechanisms that are both individualising in that they are aimed at peoples’ bodies and conduct, but also generalising through the collection of population-level statistics and policies (Foucault, 2003), and through

which peoples' capacities to act are influenced and controlled. One aspect of this control is what Bauman (2000) calls 'deliberate precarization' (p.163), the evocation of instability, danger, and risk which can be actual or perceived. An example of the deliberate raising awareness of danger is found in health promotion, which in order to encourage behaviour change, locates people in a fluid middle ground between health and illness and presents lifestyle behaviours as a risk to health. Crawford (2006) uses the term 'pedagogy of danger' (p.508) for the ways in which people understand themselves to be at risk of ill-health, risk that can be reduced or increased by engagement or lack of engagement in a healthy lifestyle. Crawford observes that, 'the commandment of health is violated with full knowledge of the transgression' (p.508), concluding that evoking fear is a necessary strategy to combat people's apparent unwillingness to maintain stringent control over their behaviour.

This perception of danger can function to regulate health behaviour on an individual level, but it is also mobilised by commercial forces in the marketing of health-related products and services. Commercial advertising adds to the mix, employing notions of risk to produce a strong emotional appeal to vulnerability and fear (Petersen & Lupton, 1996). The intersection of governmentality, neoliberalism, healthism, commercial interests and the rise of biopolitics have resulted in an ordering of life and the production of the subject according to 'risk politics' (Rose, 2001, p.1). Locating risk at the centre of biopolitics is a means of identifying particular groups or threats, and justifying strategies, interventions and targeting of those groups. Crawford (2006) highlights the role of health promotion and health education, and Hardt and Negri (2000) observe that control is increasingly maintained by citizens themselves as they internalise social norms and imperatives. Morden, Jinks and Ong (2012) trace neoliberal discourses of risk in the management of chronic conditions at the intersection of medical institutions and individuals, the outcome of which are producing subjects such as the 'expert patient'. The social contract is based on more choice and freedom for the patient, in return for which, they are expected to take more responsibility and to be compliant with medical treatment and lifestyle advice (Mol, 2007). The major assumption of this approach is that risks are managed rationally through the application of knowledge to assess and avoid health problems (Zinn, 2005). Rose (1999) includes the imperatives of

capitalism in the knowledge that defines risk, and positions subjects in relation to those risks to produce self-managing responsible health citizens who can contribute productively to the economy while minimising the resources they require. So risk discourses have a dual function in regulating the health subject to meet economic demands for labour and reduced health care costs, and to maintain and govern the social order.

Petersen and Wilkinson (2008) distinguish between ‘expert understandings of risk...framed in terms of probabilistic reason, calculation and control’ and its use in health promotion where it is ‘dramatised as danger for the purpose of promoting good health behaviours’ (p.6). The expansion of risk and risk quantification and technology have created a new category between illness and health, encompassing asymptomatic states such as metabolic syndrome and other categories of risk relating to age, gender, lifestyle, and body size. In terms of lifestyle disease, risk profiling is a common practice, in which people are invited to take part, evaluating their own risk factors. Health and risk-assessment tools once confined to clinical use are now commonly available online, particularly those related to lifestyle diseases. The British Heart Foundation and American Heart Association websites, for example, both offer online risk assessment for CHD.

Food is a particular target for risk management. The language of risk is very common in dietary advice and information, where food may be presented as both a cause of and a cure for disease. Food and eating behaviours may be designated as healthy, even medicinal, or as toxic and pathological, producing a conflicted space which must be negotiated by individuals who aim to achieve a healthy diet for themselves or their families. Despite dominant constructions of food as risky, and its management as integral to health, critical researchers have been arguing against the efficacy of this approach. For example, Vogel and Mol (2014) reject the notion that risk awareness, self-control, and abstinence from pleasure are essential for healthy eating. They assert the value of moving away from the over-coding of normative moral judgements about food and self, and encouraging people to reconnect pleasure with eating. Vogel and Mol suggest that this affective rather than cognitive approach leads to greater satisfaction, recognition of satiety and a move towards healthier food consumption.

In new forms of ‘informational biocitizenship’ (Rose & Novas, 2005, p.439), people access ‘expert’ or specialised knowledge that once was held only by professionals to inform themselves and prepare for medical encounters (Hansen & Easthope, 2007). Rather than self-management proceeding in a linear fashion from information provided by health care professionals, Morden et al. (2012) argue that it is a ‘process of experimentation, learning about bodily needs and information gathering contingent upon social context, lifestyle, perceptions of their condition and ability to act’ (p.86). Professional advice is incorporated into and filtered through these experiences, and is negotiated rather than transmitted in a simple and linear fashion. The diffusion of health information and knowledge has broken down traditional barriers between expert and lay knowledge. This dissemination has several sources, according to Crawford (2006), including the expansion and increased reporting of medical science, the growth (and commercialisation) of public health information and advice. In online communities, for example, people share and develop knowledge relating to health and illness (Hall, Grogan, & Gough, 2015; Dyke, 2013). Davison, Davey-Smith, & Frankel (1991) argue that the blurring of distinctions between lay and expert is prevalent in the area of CHD since lifestyle information is now common knowledge. They identify a ‘lay epidemiology’ of CHD according to which a typical risk profile is associated with appearance, weight, social class and behaviours relating to diet, smoking and stress. Early detection and screening programmes also contribute a middle ground between health and ill-health, creating ‘at risk’ health identities (Farimond et al., 2010), complexities which individuals negotiate in their management of lifestyle change.

The logic of lifestyle advice, that people are responsible for their health and ill-health through their engagement and non-engagement in lifestyle change, has ramifications for how people are perceived and treated by others, and critical health literature has explored the potential for stigma and discrimination in discourses of health, particularly weight, as within an individual’s control (Puhl et al, 2015).

Stigma.

Rose (2001) argues that ‘life itself’, what constitutes a good life, and how we should live it is established through medical and public health institutions. The

resulting dilemmas of how individuals are valued or can value themselves in a health valuing society (Crawford, 2006) are enacted in discourses of appearance, weight and health. Lupton (2014) argues that the continual association with fatness and illness constructs the fat body as unhealthy and as representing a burden on health-care services, and therefore as personally and socially irresponsible. It is not acceptable to publicly criticise someone for being overweight on the grounds of appearance, but the imperative of health warrants surveillance, monitoring and critique of weight on health grounds (Crawshaw, 2007, 2012). Although fat shaming and consequent body dissatisfaction are associated with weight gain rather than loss (Hunger et al., 2015), healthism provides a justification for such practices, not as misogyny or discrimination against those who fail to conform to a thin ideal, but as legitimate concern for individuals' own health and for the burden they may place upon society.

Healthism and neoliberal notions of self-discipline extend to psychological as well as physical health, and physical and mental wellbeing are held to be indivisible, illustrated in the promise of the Big Fat Problem campaign that lifestyle change will make you 'look and feel great'. But this mutuality leads to a major paradox at the heart of healthism. Health promotion, media and public health messages propound the view that people who are considered overweight need to recognise their weight as problematic before they can start to address their problems. Weight loss is constructed as empowering and requiring self-discipline and self-respect, but being overweight is understood as a state of disempowerment, a starting point that constructs people as problematic and flawed is incompatible with its supposed end points. It is not clear how individuals are able to marshal the self-esteem and self-efficacy which health behaviour models propose are necessary for lifestyle change (e.g. Bandura, 2004) when the need to engage in health behaviour change requires a recognition of a flawed and unacceptable self.

Despite evidence that shame and humiliation are not effective triggers for weight loss (Durso, Latner, & Hyashi, 2012), they form a familiar trope in weight loss narratives in the media and promotional websites for commercial weight loss programmes. Illnesses, or potential illnesses represented by such as states such as overweight, smoking, lack of exercise, can threaten valued identities and perceived

criticism or social pressures create power relations as well as shape identity. As people enter periods of ill health or identify potential future changes in health status, the self is seen as at risk and subject to disturbance and change. Lifestyle advice and changes can therefore be seen to have the potential to “empower and undermine” the self (Löfvenmark, Saboonchi, Edner, Billing, & Mattiasson, 2013, p.120).

The multifactorial aetiology of cardiovascular disease management involves multiple bodies and institutions, including government and public health agencies, and commercial interests ranging from the pharmaceutical to the diet and health food industry (Niewöhner, Döring, Kontopodis, & Madarasz, 2011). There is assumed to be a rational, agentic, responsible ‘preventative self’ within this multiplicity, able and willing to make appropriate lifestyle choices based on information provided by a community of experts. The process is aimed at minimising risk and establishing order in a sometimes chaotic world of health and illness through the production of knowledge and technology, and the dissemination of understandings and practices which reduce complexity and homogenise experience (Rabinow & Rose, 2006). This preventative self has the appeal of rationality and moral responsibility, but creates the logically inevitable stigmatisation of those who do not achieve and maintain an appropriate body. It can be seen as a form of governance, whereby the interests of the government are not imposed by the state, but are taken up and perpetuated by the population itself through processes of self-surveillance, discipline and control. Competing discourses of freedom, calculated risk and pleasure stand in opposition to the risk-aware, preventative self, and are constructed as problematic in health information, advice and promotion materials (Riley, Griffin, & Morey, 2010).

Even though some critical and biomedical approaches acknowledge the role of environmental and social factors, and call for a move away from an individual responsibility model (Webber, 2015), the underlying focus on and problematisation of obesity remains the same in both social and individual approaches, leaving people open to stigmatization on the basis of their weight (Schorb, 2013). There is evidence that neoliberal health and health promotion discourses have adverse consequences. Eating difficulties and disorders appear to be increasing with rates of obesity, and dieting is a common strategy for losing weight, but Neumark-Sztainer et al. (2007) report an association between dieting, unhealthy lifestyle behaviours and weight

gain. They found that adolescents in their study who were dieting also increased behaviours such as binge eating, and decreased breakfast consumption and exercise. Star, Hay, Quirk and Mond (2015) highlight the risk that population health campaigns reinforce behaviours associated with eating difficulties, such as controlling the amount and type of food that is eaten, while stigmatising weight, while perceived weight discrimination mediates the association between obesity and self-reported quality of life and well-being (Jackson, Beeken, & Wardle, 2015)

Inequality and discrimination.

Obesity-related discrimination is associated with outcomes relating to psychological well-being as well as eating difficulties. Puhl and Heuer (2010) trace the impact of stigma relating to dominant understandings of health, and cite the association of illnesses such as HIV/AIDS and tuberculosis with racism and other forms of discrimination. Weight stigma is recognised, but there persists a view that negative attitudes towards overweight are justified by the risk obesity represents, and that stigma may actually represent an incentive to lose weight. Anti-obesity attitudes, which are seen as a legitimate form of discrimination, affect people's chances of gaining and maintaining employment and promotion, for example (Pearl, Puhl, & Brownell, 2012). Professionals working in education and health care can also share negative social beliefs about obesity. Kirk et al. (2014) observe that patients suffer from conflicting information and ways of managing obesity, and conclude that the dominant discourses of obesity produce 'blame as devastating relation of power' (p.790). Currently in the UK, health care is rationed on the basis of weight and smoking in some NHS trusts (Royal College of Surgeons, 2016).

Government goals for improved public health are usually justified on social and economic grounds, but in positioning individuals as responsible for their health while failing to acknowledge the impact of economic, commercial and sociocultural forces, public health campaigns can be experienced as stigmatising and disempowering (Puhl, Peterson, & Luedicke, 2013). Braidotti (2013), Connell (2012), and Sparke (2016) trace a global neoliberal restructuring in the dismantling of social institutions such as welfare states and socialised medicine and an emphasis upon the power and effectiveness of market forces, individual responsibility and

choice. These discourses crowd out alternative understandings of how inequality and social injustice reduce peoples' capacities to act and compete for economic and social resources and success, reducing pressure on governments to address wider social determinants of health, such as socioeconomic inequality, poor housing, access to healthy food, and safe places to exercise.

Neoliberal approaches rarely include contextual factors, while the insistence on the agency of the individual produces a logic which can leave people who develop lifestyle diseases to experience blame from the self and others, and guilt (Willig, 2011). When weight is a fundamental marker for health, lifestyle advice is predicated on losing weight, other independent determinants of health, such as exercise and the healthiness of the food being consumed, is presented as secondary and important only in its contribution to the goal of weight loss. As I discuss below, complex and conflicting contemporary discourses of health provide a context full of dilemmas that individuals negotiate in their talk about and management of healthy lifestyle.

Dilemmas, Complexity, and Conflict in Contemporary Health Discourses.

Neoliberal health discourses and health promotion materials encompass apparently conflicting injunctions, in a consumer culture, to both control and indulge the self (Crawford, 2006). Positive health identities are available through appropriate consumption, produced through the satisfaction of conforming contemporary ideals and norms of autonomy, self-efficacy, understanding of and desire for optimal health (Davies, 2013; Wiener, 2010). Desirable but unhealthy food still has a place within discourses of healthy living; if people engage in healthy eating and exercise, they will have earned the right to release control and reward themselves with unhealthy food (Robertson, 2006). The conflicting extremes of consumption and control are resolved in discourses of a 'healthy balance' that meets capitalist societies' need for citizens to consume and spend on both health and pleasure. Ideally, people would self-regulate without the need for government controls of unhealthy substances and services such as fast food and alcohol, while limiting government spending on managing health problems that result from over indulgence. Health-promotion campaigns such as Change4Life enacts this ambiguity

in its advice to swap high-sugar for sugar-free soda rather than avoiding it altogether, despite evidence that sugar-free drinks are also associated with weight gain (Fowler et al., 2008).

Social marketing for health can be understood as a form of distant governance, located as it is within the context of neoliberal imperatives to reduce government interference and population dependence on the state (Crawshaw, 2009). Its commercial approach and emphasis on individual responsibility fulfils governments' economically motivated desire for improved health and represents a relatively low-cost means of influencing health behaviours without increasing investment in social services and structures (Crawshaw, 2009). But there is considerable complexity in the ways in which social marketing messages are taken up and negotiated by the target population.

In a study with unemployed men, Crawshaw (2012) observed that they resisted some of the assumptions and messages of social marketing campaigns, and drew on more diverse and complex understandings of health than simple paradigms of diet, exercise, weight and 'healthy choices'. The participants' health values encompassed happiness and the ability to function in their everyday lives, and they also asserted a more complex causality in their health behaviours, rejecting the cognitive model that information about risk or benefit will translate directly into behaviour change. The men talked about 'risky' behaviours in a nuanced way, identifying them as strategies to manage other risks such as stress and anxiety. They also identified financial barriers to a healthy lifestyle, stating that less healthy food is cheaper than healthier, and saw choice as limited by their financial situation. Similarly, Tischner (2013) reports that women constructed healthy lifestyle as an aspiration, but as a luxury that they could not afford, as they prioritised care of the family rather than of themselves.

Crawford (2006) predicted cynicism and a lack of trust in social marketing for health, but while Crawshaw's (2012) participants did resist aspects of social marketing messages, they also adopted the basic neoliberal tenets of individual responsibility, and minimal state interference. Behaviours such as smoking may be seen as instrumental in positive identities, especially for young people, despite

awareness and knowledge about the health risks, as in Riley, et al.'s (2010) identification of alternative management of risk in the 'calculated hedonism' of young peoples' drug use (p.345).

The contemporary social context shapes dominant discourses of health and health behaviour, but inconsistencies, uncertainties and contradictions produce health as a contested site of identity management, as people work to create a coherent, affirmative account of responsible health citizenship (Radley, 1996). The studies described above demonstrate the complexity and contradictions inherent in ways that people talk about and manage their health in the context of neoliberal-informed understandings of health, which are reinforced by public health and commercial advertising campaigns. A further layer of complexity is added when we consider romantic norms and expectations, and how these fold into and/or rub up against neoliberal healthism.

Romantic relationships are understood as natural, fulfilling biological, evolutionary and social functions (Fisher, Aron, & Brown, 2006). They are aspired to in current Western culture as a source of personal growth, fulfilment, physical and mental well-being. In consequence, health psychology and biomedical research investigates the association between relationship status and health (Uchino, 2013), establishing love as an adaptive, evolved behaviour, arising from and fulfilling biological imperatives (e.g. Der Boer, Van Buel, & Ter Horst, 2012). Despite social understandings of love as a source of happiness and well-being (Ahmed, 2010a, 2010b), Illouz (2010) highlights some of the diverse and paradoxical understandings of love in modern times, and identifies an intertwining of pragmatic and romantic aspects of love and concluding that though 'more emancipated and more egalitarian, and thus, more free and unconstrained, modern love is also counter-intuitively more rationalized than its premodern counterpart' (p.21).

Rose (1999) supports this argument, proposing that coupledness is constructed as a 'vital commodity for the purchase of good health, well-being and a securitised freedom' (p.270) and that the contained, self-observing and controlling individual is central to modern understandings and practices of coupledness. Love is thus tied into a 'model of health that massively penetrates intimate relationships [demanding] that

love be aligned along definitions of wellbeing and happiness and submitted to the iron law of utility' (Illouz, 2010, p.25). Love thus intersects with health, and is harnessed to neoliberal healthism by understandings of care as an element of love (hooks, 2000) and of relationships as a route to self-improvement. However, a reductive, utilitarian concept of love does not capture the complexity of either health or love, and the imperatives and norms of each may not always be in alignment, creating tensions that couples make sense of in their health practices.

2.3 Conclusion.

The promotion of a healthy lifestyle is inescapable in its permeation of every level of modern life. The benign and the oppressive, the personal and the political are intertwined in health information and advice. The wish for a long and healthy life seems natural and universal, and achieving health through engagement in particular 'lifestyle' behaviours is accepted as common sense, but these understandings are based upon particular views of knowledge and reality. Dominant models have been criticised for their oversimplification of biological processes and establishment of linear, causal relationships between lifestyle and health (e.g. Aphramor, 2014), while people must manage the gap between their lived experience and accepted scientific knowledge and models of health and health behaviour. Adding to the complexity of 'health assemblages', are the forces of healthism and neoliberalism, which shape health-related discourses and practices. These discourses produce understandings and norms which can attribute blame, stigmatise, and marginalise individuals, while failing to account for the complexity of determinants of health.

Critical and poststructuralist approaches offer alternative ways of thinking about health through perspectives that challenge notions of knowledge as universal and objective. According to critical theory, knowledge is multiple, relational, produced by and within discursive, historical, and cultural contexts. Medical and scientific knowledge has a special status within health-focussed societies, but poststructuralist theorists such as Foucault reveal the ways in which scientific research is itself situated and embedded within a sociocultural context. In line with the concepts of biopower and technologies of self discussed above, Massumi (2003) argues that people do not simply follow health injunctions, but that imperatives of

health produce desired identities; in fulfilling those imperatives, people come to feel they are fulfilling their own desires and potentials. It seems clear that the current state of health promotion and health psychology is full of contradictions, paradoxes, and unintended and unforeseen consequences relating to psychological and physical health outcomes.

Discourses of healthy lifestyle as preventative of ill health derive from biomedical research and clinical practice, and are sustained by public health education and campaigns, media coverage of health-related issues, and from the marketing of healthy lifestyle goods and services. Lupton and Chapman (1995) argue that ‘dictates concerning the appropriateness of food in relation to establishing and maintaining good health that are articulated by health promoters and other medical and health professionals, may be viewed as constituting a dominant belief system’ (p.478). This dominance can be seen in the prominent position of food, diet and weight in health advice, information and promotion.

Lifestyle advice is apparently simple and common sense, but individuals negotiate a more complex actuality which can be experienced as highly conflicted and contradictory. This has implications for the production of subjectivity and understandings of health (Crawford, 2006). Health advice is also frequently resisted, suggesting that competing desires and imperatives, such as the norms and expectations of romantic relationships, come into play. The complexity of modern discourses of health with their regulatory, governmental, and surveillance dimensions, thus has to be negotiated by people in their everyday lifestyle and health practices, and within their romantic relationships.

In this chapter, I drew on critical, poststructuralist concepts of governmentality, neoliberalism, and healthism to provide the context to couples’ adoption of and resistance to dominant discourses in their management of each other’s healthy living and lifestyle change. To understand how caring and health-related practices are conceptualised and constructed within romantic relationships, I use the following chapter to explore the literature on couples and health. I will consider current models of couples’ health behaviour and their understanding and

management of healthy lifestyle advice and practices, particularly research in the area of CHD, as the most common 'lifestyle disease' for both men and women.

Chapter 3 Couples and Health

Introduction.

In Chapter 2, I explored current understandings of health as within the control, and therefore the responsibility of the individual, and considered the consequences for subjectivity of this moral ‘imperative of health’ (Foucault, 1980, p.170). Illnesses such as CHD are increasingly designated as ‘lifestyle diseases’, and understood to be caused, prevented, and cured by behaviours relating to diet, exercise, smoking, and drinking. Health information and advice take an individualistic focus, encouraging people to reduce their risk of lifestyle diseases. But this individual focus does not take into account the 63% of people in the UK who live with an intimate partner (ONS, 2014), whose health behaviours consequently may affect and be affected by others. Social relationships represent an important predictor of mortality, comparable with factors such as smoking and greater than those observed for obesity, for example (Holt-Lunstad, Smith, & Layton, 2010), with evidence that people in long-term relationships have lower incidence of CHD, and better recovery from acute cardiac events (Idler, Boulifard, & Contrada, 2012; King & Reiss, 2012; Sher, et al., 2014).

In this chapter, I consider health and illness in the context of long-term relationships and examine the findings that couples experience health benefits compared with those not in long-term relationships. I explore the main theories that account for improved health outcomes particularly in the context of CHD. The reasons for choosing CHD are firstly, that it is the leading cause of death for men and women globally, giving it a broad relevance. Secondly, the aetiology of CHD includes psychosocial as well as lifestyle factors, with indications that emotional and social-relationship functioning are involved, which has implications for people in long-term relationships. Finally, CHD, lifestyle factors and behaviours are particularly salient in biomedical and health psychology research as well as in health

promotion and policy, forming a wider social context within which couples understand, talk about and manage lifestyle and lifestyle change.

The purpose of this literature review is to highlight and draw together the range and content of existing research to identify the components of couples' health and lifestyle behaviours that need to be accounted for in any model or theory of relationships and health. This literature's scope and limitations provide the basis for my research questions and the rationale for an alternative theoretical framework which will be presented in Chapter 4. Below, I set out the search strategy for the literature review, provide an overview of and definitions relating to CHD and its relation to lifestyle change, before presenting my review of the research evidence for how and why relationships may impact on lifestyle management and recovery from CHD.

Scope and search strategy of the literature review.

The literature review began with the search terms 'couples', 'coronary heart disease', 'lifestyle' in search engines including PsycNET, PSYCHinfo, Web of Science, Google Scholar, and the search narrowed to papers published since 2000, after the identification of seminal and classic papers. Theory papers were also read for understanding of the constructs raised in these papers, e.g. attachment, but then the search was limited to CHD, and I included both quantitative and qualitative research. I also conducted forwards and backwards citation searches, and author searches. I excluded other illnesses such as heart failure and mediating or coexisting conditions such as anxiety and depression, and included research on both cohabiting and married couples, in line with evidence that the health benefits are similar for both groups. Research on non-cohabiting couples was excluded to maintain a focus on those with a shared lifestyle.

Below I give a brief overview of CHD in the section below, its status as a lifestyle disease, and the lifestyle changes that are recommended after diagnosis, before presenting the main theories and approaches that have been used to examine couples' health practices and outcomes.

Coronary heart disease.

One of the most robust findings in the area of couples' health relates to the incidence and survival of CHD. CHD is the single most frequent cause of death worldwide (WHO, 2015), with 1 in 6 men and 1 in 7 women dying from CHD in Europe (Steg, et al., 2012). Across countries and cultures, CHD is associated with modifiable risk factors such as smoking, high blood pressure, high cholesterol, abdominal adiposity (body fat deposited around the waistline, giving a high waist:hip ratio), and psychosocial factors including stress, depression, and a lack of social support (Chida & Steptoe, 2008; Yusuf et al., 2004). CHD develops when the deposition of fat, primarily cholesterol, narrows the arteries that supply blood to the heart muscle, a process that typically happens slowly over many years or decades. When heart muscle is deprived of oxygen in this way, its functioning is impaired, limiting exercise capacity and causing chest pain on physical exertion (which is referred to as 'angina').

The lay term 'heart attack' usually refers to a myocardial infarction (MI), which occurs when an area of heart muscle is abruptly deprived of oxygen (ischaemia), resulting in cell death, a process which takes place over several hours. This occurs when a heart artery that is already partially narrowed by fat and cholesterol abruptly clots off. Life-threatening disturbances in the heart's rhythm, termed 'arrhythmias' can occur when heart muscle is deprived of adequate oxygen supply in this way, and can lead to cardiac arrest. Death can also occur because the damage to the heart impairs its pumping action, resulting in heart failure, which can occur hours, days or even years after the initiating MI, and the likelihood of which is related to the size of the MI. Patients' symptoms can range from mild to severe pain or breathlessness, and so their diagnosis of CHD may be more or less distressing and traumatic for them and their partners depending on their experiences.

Healing after MI takes place over five to six weeks, leaving scar tissue. The acute treatment of an MI aims to restore blood supply, or revascularise, the area before cell death is complete by opening up a narrowed blood vessel either by using drugs or procedures including percutaneous catheter intervention (PCI), commonly using a device called a stent, or coronary artery bypass grafting surgery (CABG),

where a blocked artery is bypassed using a segment of artery or vein taken from elsewhere in the patient's body (Thygesen, Alpert, & White, 2007). These same procedures can also be used to treat angina in patients with stable CHD (i.e. where an MI has not occurred). As with the symptoms of a CHD event, treatment varies in its impact on patients, with stents being less invasive and painful, and typically having a quicker recovery time than CABG.

In addition to medical and pharmacological treatment, patients diagnosed with CHD are advised to: stop smoking; regulate their diet to increase consumption of fruit and vegetables, fish, and monounsaturated fats (such as olive oil); reduce consumption of saturated fat, red meat and dairy products; lose weight; take part in cardiac rehabilitation programs and sustain an increase in physical activity; and manage stress (Steg, et al., 2012). In their meta-analysis, Iestra et al. (2005) report a 35% reduction in mortality risk for smoking cessation, and an approximately 25% reduction in risk of death or MI for participation in an exercise program. Despite the evidence supporting the role of cardiac rehabilitation in reducing cardiovascular risk factors, fewer than 50% of eligible patients completing globally (Dalal, Doherty, & Taylor, 2015). Lifestyle change is difficult to sustain as well as initiate; less than 50% of patients undergoing CABG maintain lifestyle changes to diet and exercise at six month follow-up (Arrigo, Brunner-LaRocca, Lefkovits et al., 2008; Jones, Schneider, Kaminsky et al., 2007).

It is clear that with their shared living environment, these recommendations have implications for couples in the prevention and treatment of CHD, for which couples in long-term relationships have reduced risk (Kilpi, Kontinen, Silvertainen, & Martikainen, 2015). In addition, Boulifard, Idler and Contrada (2012) report that married people had significantly better survival and functioning after CABG surgery, indicating that relationship status is involved in recovery as well as incidence of CHD.

In summary, CHD is a common condition, strongly associated with modifiable risk factors relating to blood pressure, cholesterol, smoking, exercise and diet. The prevention of CHD through lifestyle change is a major global public health goal (WHO, 2016), but psychosocial factors, including social support and depression

also represent significant risk factors (Yusuf et al., 2004). Couples' shared environment may mitigate, but also potentially contribute to, risks of developing CHD, and in the following literature review, I examine the approaches and evidence for the associations between intimate relationships and CHD.

3.1 Health Psychology of Intimate Relationships and Health.

Durkheim's late 19th century study, published in English in 1957, reported that suicide rates were higher among widowed than married men and women, providing early evidence for the influence of interpersonal and social factors on health, and for the protective effects of intimate relationships (Durkheim & Simpson, 2002). Subsequent research, particularly over the past 30 years, has confirmed that couples generally have better health and live longer than those not in long-term relationships. (e.g. Holt-Lunstad & Newton, 2001; Holt-Lunstad, Smith, & Layton, 2010).

The pattern of these benefits is complex, however, with evidence of concordances between intimate partners for ill-health as well as for health. Because of their interconnected lives, couples' health and health-related practices are usually intertwined. Couples are likely to share lifestyle behaviours, including smoking habits and diet, for example, which may contribute to concordances for the major risk factors for CHD (Di Castelnuovo, Quacquarello, Donati, de Gaetano, & Lacoviello, 2009). Variations in health benefits have also been attributed to differences in relationship style and quality, and to the communication style of health interactions (Holt-Lunstad & Smith, 2012; Kiecolt-Glaser & Newton, 2001; Markey, Markey, & Birch, 2008; Rendell et al., 2011). I will present an overview of couples-health research and broad theories that account for couples' health benefits, before examining the main theories that have been used to account for variations in health outcomes in CHD.

Theories of health selection and social causation have been used to account for the health benefits that accrue to couples. The former proposes that people who marry or cohabit may be healthier than those who remain single, a selection process that contributes to improved health outcomes. Social causation, on the other hand, suggests that factors arising from the relationship rather than individuals' initial

health status is a stronger influence on couples' health (Wyke & Ford, 1992; Gottman & Notarius, 2000). Social causation itself is hypothesised to have four determinants: benefit or deficit from differences in material resources; social support; health behaviours; and stress.

The first of these, the effect of material resources, is modelled on the association between economic deprivation and health with the greater financial security experienced by couples compared with their single peers having a positive impact on health (Hahn, 1993). A second hypothesis is that social support - the broad, health-protective effects of strong social networks – accounts for health benefits for people in long-term relationships (Thoits, 2004). Thirdly, a behavioural pathway suggests that couples are less likely to engage in unhealthy, and more likely to engage in healthy behaviours compared with single peers (Wyke & Ford, 1992). A final pathway that may account for couples' health outcomes is that relationships may protect from, but also contribute to, stress. Stress can be directly connected with relationships, such as relationship breakdown, or can be more diffuse, such as that experienced by people who have low rates of relationship satisfaction. Uchino (2013) suggests that some groups are particularly vulnerable, with the poor health outcomes of those who have experienced relationship loss or breakdown possibly skewing population statistics. The complexity of intimate relationships points to the likelihood of multiple effects, such as both selective and protective forces coming into play, as healthier people may be more likely to enter intimate relationships and also to benefit from health protective effects (Kim & Waite, 2014).

Despite the well evidenced concordance for risk factors, health, and disease for couples in long-term relationships (De Castelnuovo et al., 2009; Kilpi, Konttinen, Silvertainen, & Martikainen, 2015; Meyler, Stimpson, & Peek, 2007), less is known about the mechanics of processes that may confer these benefits or produce poorer health outcomes. In trying to identify these mechanisms, several dominant psychological approaches have been used as a framework for understanding the ways that couples manage their own and each other's health. Below I consider four key theories, models and approaches used to examine couples' relationship states and practices and processes that mediate CHD, and then evaluate the contributions and limitations of these approaches to understanding couples' health behaviour.

Theories of intimate relationships and health.

Four commonly used theoretical frameworks in the study long-term relationships in lifestyle diseases such as CHD include: social support; social control and interdependence theory; attachment theory; and relationship quality. Below I outline each one and examine their application to couples' health and CHD, and then evaluate the findings and implications of research from this perspective.

Social support.

Social support is the network of social contacts that can provide material and emotional support to an individual, and is strongly associated with health outcomes (Fowler & Christakis, 2010; Thoits, 1982), and is theorised to reduce isolation, and create norms of, and motivation to, comply with protective health behaviours (Durkheim, 1957; Meyler, Stimpson, & Peek, 2007; Thoits, 1983; Williams & Fredriksen-Goldsen, 2014). Marriage and cohabitation typically increase social integration through the establishment of relational ties to partner, family and wider social groups, and there is evidence that people with more social connections are less likely to engage in risk behaviours such as smoking, for example (Fowler & Christakis, 2010). Social support theory proposes that there is nothing special about marriage or long-term relationships – they just tend to increase the size of individuals' social networks and potential sources of support, which are generally good for health (Thoits, 2011).

Social support is understood to be dynamic, varying over the lifespan and showing complex interactions with other determinants of health such as socioeconomic status, gender and culture (Bartley, Martikainen, Shipley, & Marmot, 2004). As people age, their social networks are more likely to consist of family connections, so that people who are married and in long-term relationships tend to have larger social networks. Social changes, such as declining rates of marriage, therefore have implications for health according to models of social support (Wrzus, Hänel, Wagner, & Neyer, 2013). The Samaritan's (2012) study into men and suicide, for example, indicates that current demographic changes are putting men at particular risk of social isolation, with mid-life men more likely than ever before to be living alone against a backdrop of a gradual decrease in the average size of social

networks over the past 35 years (Wrzus et al., 2012). Although the processes are not well understood, social support is theorised to affect health through physiological as well as behavioural mechanisms, and is particularly associated with changes in cardiovascular physiology (Uchino, 2006).

There are two main models of how social support protects health. Stress-buffering models propose that social support protects against stress in times of adversity, and therefore mitigates the effects of stress on health (Cohen & Wills, 1983; Thoits, 1983, 2011), while the ‘Main Effect Model’ suggests that beneficial effects of positive emotions and experiences operate even in the absence of stress (Cohen & Wills, 1985). The association between social support and health outcomes are robust, but the concept itself is broad, covering a wide range of support-giving behaviours. There are two commonly used categories of support: emotional support (caring, encouragement, and sympathy) and instrumental or practical support (material, informational, or behavioural assistance), which may function independently and differently (Thoits, 1982, 2011). For example, Molloy, Perkins-Porras, Bhattacharayya, Strike, & Steptoe (2008) report that practical support rather than emotional support, predicted adherence to medication in patients with CHD. This finding was independent of relationship status (though unmarried participants were more likely to report low levels of practical support). Marital status predicted attendance at cardiac rehabilitation, while practical support predicted the number of sessions attended. A further distinction is between actual and perceived support, as interestingly, perceived levels of support have been shown to better predict health outcomes than received support. This may be due to the poorer health of people who require such support, or because self-efficacy and self-esteem may be adversely affected by needing rather than providing social support for others (Uchino, 2009; Lett et al., 2005).

The application of the concept of social support to couples’ health behaviour in the context of CHD reveals strong associations between partner support and physical and psychological functioning and recovery, but also findings that indicate the complexity of the concept, and the behaviours and dynamics of couple health interactions. Low social support is associated with an increased risk of CHD, and it has been used to explore couples’ health behaviours after diagnosis, with spousal

support associated with positive health behaviours and improved mental health (Franks, et al., 2006; Lett et al., 2005; Rutledge et al., 2004). However, a large, longitudinal study investigating the role of social support in recovery from CHD and its association with psychobiological factors among older couples did not demonstrate expected correlations between social support and depression, quality of life, nor heart rate variability (HRV) – a predictor of CHD events (Hutton, 2013). The only significant finding was that social support is protective against anxiety, a possible indirect pathway the development of CHD. In an extension of these findings, studies aimed at increasing the effectiveness of social support within long-term relationships have also generally failed to achieve significant change in health outcomes (Lett et al., 2005).

The diversity of supportive behaviours is also illustrated in three behaviours associated by Coyne and Smith (1991) with social support: ‘protective buffering’ (where a spouse hides their level of illness or anxiety from their partner), ‘active engagement’ (a shared, communicative approach) and ‘overprotection’ (anxiety and underestimation of a spouse’s capacities). These behaviours may increase or decrease self-efficacy, an individual’s belief in their capacity to achieve a goal. In their study of couples’ coping in the aftermath of a diagnosis of CHD, Coyne and Smith (1991) demonstrated that patients’ ratings of their own self-efficacy predicted future functioning better than physiological markers following discharge from hospital. There was a negative association between patients’ protective buffering and their self-efficacy, while wives’ protective buffering, but not overprotection, contributed to patient self-efficacy. The authors account for this asymmetry by arguing that partner support can bolster self-efficacy, and facilitate in engagement in lifestyle changes and the resumption of old activities, but may also undermine self-efficacy through the underestimation of partner’s capabilities.

Dynamic effects between partners’ support behaviours produce further complexity, as Vilchinsky, et al. (2011) report. Patient perceptions of their partner’s active engagement, overprotection, or protective buffering predicted the effect of those behaviours on depressive symptoms and smoking cessation following diagnosis of CHD, suggesting that the effects of social support vary according to the type of support, perception of that support, and particular health outcome. Not only

are couples' support interactions complex, but they may operate differently for men and women (Fuhrer & Stansfield, 2002). Grewen, Girdler, Amico, and Light (2005) report that measures of hormones such as cardio-protective oxytocin, stress-regulating cortisol, and blood pressure are predicted by perceived partner support and warm partner contact, with stronger effects for women, which are not predicted by the model of physiological pathways. Unpredictable findings, such as those above, indicate that the mechanisms by which social relationships benefit health are not well understood (Cohen & Janicki-Deverts, 2009; Thoits, 2011). But what they highlight is the importance of emotional, behavioural and material aspects of health supporting behaviour, adding to the complexity of the processes by which social support contributes to health.

In summary, social support consists of interpersonal behaviours and interactions that either buffer against stress and adversity, or which promote health through positive physiological and psychological effects. Social support literature broadens the focus of research from individual to relational factors, with longitudinal studies in particular, showing the importance of long-term relationships to health (Fowler & Christakis, 2010). Social support also provides a perspective on couples' health in the context of CHD, with evidence that couples' higher levels of social support is protective against and instrumental in recovery from CHD. But the construct is clearly a complex one, encompassing different types and partner perceptions of support, which together with the dynamics of giving and receiving practical and emotional support to partners, produces considerable variability in couple health interactions and outcomes. The scope of the concept presents challenges to research aiming to measure its effects, and importantly, it is not clear that social support can be easily manipulated to improve health outcomes. One aspect of social support, social control, has been studied independently in a more fine-grained exploration of social support in order to address these issues, an approach that I will explore in the following section.

Interdependence theory and social control.

Interdependence theory offers a framework for understanding couples' health-behaviour, attributing health benefits to a shift in the object of partners'

motivation from the self to the relationship, leading to mutually supportive coping and cooperative health-enhancing behaviour (Lewis et al., 2006). Within interdependence theory, social control refers to the ways that couples engage in direct attempts to influence each other's health-related behaviour. Encouragement to engage in healthy practices and the discouragement of health-compromising behaviours such as smoking is theorised to account for couples' health benefits (Lewis & Butterfield, 2007; Lewis & Rook, 1999; Tucker & Anders, 2007; Umberson, 1987), and may take the form of warning or more indirect attempts to control diet, for example (Lewis & Butterfield, 2005; Rook et al., 2010).

Lewis and Butterfield (2007) report that direct communication about health behaviours was perceived more positively than indirect, and that bilateral influences and practices were also preferred to unilateral social control attempts. Positive control behaviours, such as encouragement, were more effective than negative behaviours such as inducing fear. Increased levels of social control were associated with both positive (compliant) and negative responses (ignoring, hiding, or doing the opposite of the encouraged behaviour). The authors found that exercise was the most frequent focus of social control attempts, followed by diet, accessing health care, adequate sleep, and weight loss, and there was no indication of gender differences in the focus of health attempts or levels of social control. But as with social support, social control does not produce consistently positive interactions and outcomes. Attempts to influence each other's health can have mixed levels of success and can produce lower compliance with health behaviour change (Franks et al., 2006). Social control can be problematic for the relationship, evoking resistance or conflict, dual effects that may account for variations in the level of health benefit experienced by couples (Rook, Thuras, & Lewis, 1990), and several researchers have examined the variability in partner perceptions of and response to control attempts more closely.

Lewis and Butterfield (2007) identify both positive social control tactics, which include 'persuasion, rational logic, modelling, and positive reinforcement' (p.301), and negative tactics which involve showing negative emotions such as disapproval, or the inducement of negative emotions, such as guilt or fear, in a partner. These are not universal values, however. Partner perception of social control appears to be a better predictor of outcomes than the particular strategy that is used.

Positively and negatively perceived influence attempts are associated with positive and negative health behaviours and health outcomes respectively (Tucker & Anders, 2001). Dyadic effects, whereby each partner's social control tactics and behavioural reactions interact with each other, also contribute to variability in couples' interactions and outcomes (Lewis & Butterfield, 2007). These factors and dynamics indicate the complexity and unpredictability of couples' social control attempts, which is reflected in variable findings when the theory is applied to patients with CHD.

Models of relationship functioning and social control suggest that open communication and control attempts should predict lifestyle change, but Franks, Stephens, Rook, Franklin, and Keteyian (2002) found inconsistent results. Listening and encouragement did not predict a spouse's behaviour change, and social control attempts were associated with less engagement in lifestyle change. Thus, although there may be links between some aspects of health or relationship functioning and social control, these may not translate into measurable health benefits. Joekes, Maes, & Warrens (2007) report that although active engagement in each other's health (a dimension of social support and social control) improved self-reported quality of life among patients following MI, their physical functioning was unaffected.

Rook et al. (2010) attribute inconsistent findings for the efficacy of social control to the presence of a dual effect, proposing that while attempts to influence health can encourage healthy behaviours, they can also cause distress and conflict. Tucker (2002) reports that social control evoked negative feelings in the context of poor relationship satisfaction, while Rook et al. (2010) suggest that relationship norms, expectations, or beliefs about how much a partner should be involved, determine the extent to which attempts are unwelcome or unwanted. The complexity of the interplay between possible expectations, provision of support, and responses to that support, as well as contextual factors, such as the specific illness that a partner is suffering from, may account for inconsistent and unpredictable results (Wrubel, Strumbo, & Johnson, 2010). Partners can experience parallel positive and negative responses to and perceptions of social control. August, Abbamonte, Markey, Nave, and Markey (2016) report that participants experienced guilt at partners' attempts to

influence their weight, but nonetheless perceived support and influence attempts positively.

Reflecting on why some attempts to influence health behaviours might be perceived negatively within an intimate relationship, Murray, Griffin, Rose, and Bellavia (2006) propose a cascade of counter-productive effects. Social control may be understood as a lack of acceptance, which is associated with lower self-efficacy and with lower relationship satisfaction, both of which predict worse health outcomes. Social control attempts have the potential to be viewed as criticism, and so lifestyle change may produce dilemmas and conflict among couples with CHD, who can experience a partner's support or encouragement for lifestyle change as critical, controlling, or as unwelcome pressure (Goldsmith, Lindholm, & Bute, 2006). The paradoxical meanings of lifestyle advice and change have implications for health outcomes, since lifestyle change can be understood as empowering and protective, but is also as a reminder of illness and loss. Goldsmith et al. (2006) suggest that this contradiction may influence couples' communication about, perception of, and response to joint management of change.

Theories of interdependence and social control propose that health practices and interactions are relational and interdependent, rather than arising from individual factors and traits, focusing the type and quality of couple health interactions and communication, and the potential for couples' health interactions to produce harm as well as benefits. The third theory in this review, attachment theory, proposes an alternative framework for understanding the motivations, practices, and outcomes of couples' health behaviours.

Attachment theory.

Attachment theory proposes that parent-child bonding is an innate behaviour that evolved to optimise child survival and development (Ainsworth, 1979; Ainsworth & Bowlby, 1991). Bowlby focused on parent-child interactions, arguing that unrestricted access to the primary attachment figure (usually the mother) produces a secure attachment, while incomplete or disrupted bonds produce maladaptive avoidant or insecure styles which affect future interpersonal functioning. Attachment styles and behaviours are characterised by the caregivers'

responsiveness and commitment to the child, which are theorised to satisfy a child's needs for security and nurturing, and support the development of secure attachment that the child carries forward into its adult life (Ainsworth & Bowlby, 1991). Hazan and Shaver (1987) applied attachment theory to adult relationships, and proposed that romantic love has a similar care-giving function to parenting. Adult attachment is understood as an adaptive behaviour which benefits people in intimate relationships, shaped by experiences in childhood and past romantic relationships, which then influence relationship behaviours including support seeking and caregiving (Mikulincer & Shaver, 2012; Uchino, 2013).

Attachment theory draws attention to the role of childhood experiences in the development of adults' relationship functioning, and offers a framework for exploring patterns of security, anxiety, and avoidance within intimate relationships. The association between attachment style and health arises from the dimensions of anxiety and avoidance upon which people with more and less secure attachment are said to differ. Attachment anxiety is manifest in fear of abandonment and rejection, while avoidance is characterised by difficulty with emotional regulation, an avoidance of intimacy, and discomfort with giving and receiving support. Attachment styles are thus hypothesised to influence health through physiological (e.g. stress-related hormones) as well as behavioural pathways (e.g. lack of help seeking) (Mikulincer & Shaver, 2008; Robles & Kane, 2014; Uchino, 2013), and so may affect health in direct and indirect ways.

Studies indicate dyadic patterns in the ways that attachment style affects physiological, physical, and psychological responses to relationship conflict. Less secure attachment styles are associated with poorer diet and less physical activity for women, though not for men (Davis, Sandberg, Bradford, & Larson, 2015), while Pietromonaco, DeBuse, and Powers (2013) propose that adult attachment style 'gets under the skin' (p.63) via the body's stress-response system, with stress-related hormones such as cortisol accounting for how attachment affects CHD risk in the context of intimate relationships. Anxiously attached wives and avoidant husbands showed the highest cortisol stress responses of the different attachment styles and pairings, which suggests that the interaction between partner's different styles may influence health outcomes, and may also account for inconsistent results in research

examining direct links between attachment style and health outcomes (Beck, Pietromonaco, DeBuse, & Powers, 2013).

Although there is some evidence on a broad level for an association between attachment style and the number of chronic health conditions in a large population sample (McWilliams & Bailey, 2010), it has been applied to couples and CHD only relatively recently. Inconsistent findings have failed to demonstrate clear associations between attachment style and physiological markers for diseases and for clinical endpoints in conditions such as CHD (Robles & Kane, 2013; Uchino, 2013).

The fourth approach to research into couples and health is not based on a single theory of couple relationships, but hypothesises an association between relationship quality and health which has been used in conjunction with the three theories outlined above, and which I will examine in the following section.

Relationship quality.

Kiecolt-Glaser & Newton (2001) argue that relationship quality as well as status has an influence on health, and suggest that variability in relationship satisfaction accounts for inconsistent patterns of health benefits for couples. Marital quality is broadly defined as self-reported evaluations of marriage or intimate relationship along positive and negative dimensions. The former includes happiness, support, and satisfaction, and can also include openness and responsiveness to each other's needs, while negative dimensions include conflict, hostility, and tension (Bradbury, Fincham, & Beach, 2000; Fincham & Beach, 1999; Robles et al., 2014). Robles et al. (2014) acknowledge that 'sharing of space, time, resources, and investments creates unique arenas for both support *and* conflict' (p.141), and argue that these dimensions are distinct and operate independently rather than being mutually exclusive. In recognition of dual pathways, relationships reported to be high in both negative and positive relationship quality are designated as ambivalent, while those low on both negative and positive dimensions, involving low costs but also low benefits are designated as indifferent (Kim and Waite, 2014).

Although the construct of relationship quality is independently associated with health (Robles et al., 2014), it forms a point of overlap with other approaches to

health and relationships. Researchers who adopt theories of social support, social control, and attachment may also measure relationship quality as an indicator of relationship functioning and as a potential mediator between attachment style, for example, and health outcomes. Relationship quality is theorised to affect health through biological mediators which involve the endocrine, cardiovascular and immune systems (Kiecolt-Glaser & Newton, 2001). Recent studies which have examined relationship conflict, perceived positivity, satisfaction, and the development of CHD report that marital discord (characterised by higher levels of dominance and hostility and lower warmth during disagreement) is associated with a higher degree of coronary artery calcification, a predictor of CHD (Smith, Uchino, Berg, and Florsheim, 2012). Negative relationship quality is associated with negative emotional states which are independently associated with the development of CHD. An association between relationship quality and metabolic syndrome, a precursor to CHD, has been shown to be mediated through depressive symptoms in men and women (Henry, Smith, Butner, et al., 2015), indicating that negative emotions arising out of, or coexisting with poor relationships could account for poorer health outcomes.

Evidence for a link between relationship quality and CHD is provided by Smith et al. (2012), who found that discordant couples had greater levels of coronary artery calcification, a marker of CHD, than non-discordant couples, while Janicki et al. (2005), and Gallo et al. (2003) in their longitudinal study, found that marital satisfaction predicted carotid intima media thickness (IMT), a reliable indicator of future CHD. Although the theoretical link between relationship satisfaction and physiological pathways linked to stress and negative emotions has considerable support, research investigating this model has also provided some equivocal results. Although low marital quality has been associated with higher blood pressure, a contributory factor to the development of CHD, in a longitudinal, population study, whose large cohort of 1,356 married or cohabiting couples should have provided statistically robust results, the relationships between blood pressure and couples' reports of stress and relationship quality were inconsistent. Women's stress predicted their male partner's stress, blood pressure and negative spousal evaluation of relationship quality, but poor relationship quality only predicted higher blood

pressure when both partners reported low satisfaction (Holt-Lunstad, Birmingham & Jones, 2008).

Unpredicted interaction and gender effects, such as those reported above, indicate that wider social factors may contribute to gender differences in the model of physiological stress as a mediator between relationship quality and the development of CHD. Bradbury, Fincham, and Beach (2000) recognise the multiple dynamic factors, both micro- and macro-level, involved in relationship satisfaction, and emphasise the need for longitudinal studies that contextualise relationship processes within wider sociocultural milieus. Fincham (2003) proposes that a focus on negative emotions as a predictor of relationship quality may be less useful than considering the more powerful effect of positive behaviours such as support, although the association between divorce, relationship conflict, and CHD supports the existence of dual processes for the effects of negative and positive relationship quality and experiences (De Vogli, Chandola, & Marmot, 2007; Smith, et al., 2011; Smith, et al., 2012). There is evidence of dynamic effects in research that indicates that the risk factors associated with CHD also predict marriage quality (Baron et al., 2007; Renshaw, Blais, & Smith, 2010).

As noted earlier, research on couples' health has identified inconsistent gender differences, which are also found in investigations into relationship quality and health, indicating that wider social factors may also play a role (Kim & Waite, 2014). Robles et al. (2014) found no gender differences in health outcomes, while King and Reis (2012) found that men expressing high relationship satisfaction experienced significantly improved 15-year survival, but there was no significant difference for women. The authors suggest the survival advantage may be attributable to differences in the emotional and social support and encouragement to adopt a healthier lifestyle that men and women provide for each other. Smith et al. (2013) propose a physiological pathway for women's smaller health benefits from marriage in their study indicating that heart-rate variability (a predictor of CHD events) was correlated with relationship quality for men and women, but there was only an association between heart rate variability and negative marital interactions for women, suggesting they may suffer stronger cardiovascular and stress responses to relationship conflict than men. Global measures of relationship quality may mask

complex patterns of satisfaction and dissatisfaction within relationships. Smith et al. (2012) found that self-reports of marital quality were not associated with increased CAC, a marker for CHD, but that factors such as a partner's low warmth were significantly correlated for women, while a partner's controlling behaviour was correlated with CAC for men.

A focus on interaction quality rather than global measures of relationship satisfaction or quality has also been used to understand the links between relationships, and health outcomes (Uchino, 2013). Joseph, Kamarck, Muldoon, and Manuck (2015) used ecological momentary assessment (EMA), whereby couples evaluated the quality of partner and non-partner interactions every hour throughout the study period of four days. A higher rate of positive interactions was associated with lower carotid IMT, while more negative interactions were associated with higher IMT. Global marital quality, personality, and other risk factors, including gender, were not significantly correlated with IMT, suggesting that the quality of couples' interactions may have a greater effect on the development of CHD than more global measures. This has implications for health interventions and advice that can potentially evoke negative, blaming or anxious interactions between partners, although the physiological pathways between couple interactions, proxy measures such as blood pressure and carotid IMT, and health outcomes have not been clearly demonstrated.

Researchers in the relatively narrow field of relationships and health sometimes draw on more than one approach, exemplified in the development of the concept of ambivalence. As mentioned earlier, positive and negative dimensions of intimate relationships are not considered mutually exclusive or polar (Kim & Waite, 2014). Based on the observation that relationships may involve both positive and negative interactions and aspects, relationship functioning may not be well captured by global positive or negative evaluations. Uchino, Smith and Berg (2014) used a measure of positivity or ambivalence derived from perceptions of interactions as helpful or upsetting, and designated interactions as ambivalent if negative evaluations outweighed positive evaluations. Although main effects were non-significant, the authors report a significant interaction effect, where CAC scores were higher when both partners viewed each other as ambivalent.

Some studies of relationship quality also consider emotional dimensions of relationships and couple interactions. Research that measures the quality of couple interactions rather than using global measures of relationship quality claims to have established links between emotional states and pathophysiological markers for CHD. Within the broad finding that couples' relationship quality is associated with health, there are also concordances for ill-health, and generally effect sizes are small (Robles, Slatcher, Trombello, & McGinn, 2014), which indicates, as with the previous approaches, that there are multiple and dynamic factors, which despite the plausibility of the association between relationship quality and health, contribute to inconsistent results. Gottman & Notarius (2000) argue, however, that emotion remains an important and underdeveloped avenue for future research in the context of intimate relationships and health.

The previous sections covered four common approaches which establish connections between intimate relationships to the incidence of and recovery from CHD. Long-term relationships appear to be protective against heart disease, but these benefits are not universal, with potential for increased risk for some partners and couples (Nealey-Moore, Smith, Uchino, Hawkins, & Olson-Cerny, 2007). To account for this variability, social support, social control, attachment style, and relationship quality are theorised to affect couples' health through direct interactions relating to lifestyle management and health behaviours, and also indirectly through physiological processes. Thus, these theories attempt to account for the embodiment of relational process and emotions, how attachment style, for example, 'gets under the skin' (Pietromonaco et al., 2013, p.63).

What the different mainstream theoretical and quantitative approaches have in common is the normalisation of the interconnectedness of intimate relationships and health, taking for granted that a 'good' relationship is one where positive health behaviours will take place, and that suboptimal health functioning is indicative of dysfunction, reflecting and perpetuating societal norms of caring relationships (e.g. Smith, Baron, & Grove, 2013). But studies of social control in particular indicate that engagement with a partner's health can be problematic and counter-productive as well as beneficial. These different approaches all provide valuable insights into intimate relationships and health, and indicate the complex and dynamic ways in

which couples may affect each other's health and lifestyle, but inconsistent findings in the application of these theories and approaches suggest that other dynamic, interactional processes, as well as wider social factors also contribute to the complexity of couples' health behaviours and functioning.

Limitations of mainstream health psychology approaches.

Bringing this literature review, together there are several limitations which impact on our ability to understand the complexities of couples' mediation of health outcomes. Factors that may limit the applicability of quantitative findings relate to the theorisation and measurement of health and aspects of intimate relationships, given that these are complex, dynamic constructs. Definitions of relationship satisfaction and quality can vary, and inconsistencies in the measurement of these concepts across the literature can make it difficult to trace clear lines of causality between relationship factors and the physiological processes that mediate between relationships and health outcomes (Kamp Dush & Taylor, 2012; Robles et al., 2014; Uchino et al., 2013). Broad, global measures do not uncover the specific, instrumental ways that couples talk, but there are limits to the feasibility of quantifying the dynamics of talk, especially when contextual factors are added into the equation (Goldsmith and Miller, 2014; Sheridan & Julian, 2016).

One result of this complexity is the inability of a single model or theory to fully capture the dynamics of couple health interactions. Farrell and Simpson (2016) identify a number of parallel relationship processes, including attachment and hostility, upon health outcomes and stress responses. But they acknowledge that this picture is complex and fluid, with factors such as lifespan, relationship length, and caretaking roles also influencing relationships and health outcomes. Similarly, Robles and Kane (2013) advocate using attachment theory in conjunction with other frameworks, such as personality and normative social processes, to better understand couples' health interactions and outcomes, though modelling becomes increasingly complex when other approaches are added to an already variable and dynamic construct. Combining theoretical approaches may add scope to the theoretical model, but reduces the potential for practical application of relationship models in clinical settings.

Some of the difficulties of applying theories and models in interventions are highlighted by Voils et al. (2013), who report the limited effectiveness of a large-scale couples' lifestyle intervention. They found it difficult to recruit and retain couples on the programme, and although their intervention had some impact on participants' lifestyle behaviours, there were no differences in clinical end points, such as cholesterol levels. Other intervention studies also fail to show effects in expected directions (Jaarsma et al., 2008; Cole, Smith, Hart et al., 2013), and many studies which attempt to model the effects of couple interaction on health outcomes in patients with CHD also report equivocal results (e.g. Vilchinsky et al., 2011). Applying theories in the context of illness also indicate further complications to existing models of relationship style and functioning, with bi-directional effects between health and relationships.

Folkman and Moskowitz (2004) reflect on the reasons why it is so difficult to model coping and health management behaviours and why interventions based on such models achieve less than anticipated success. The wide range of cognitive and behavioural responses to stress events such as cardiac illness, are dynamic, complex processes, embedded in a patient's unique environment. They argue that factors such as the patient's beliefs about the event, and the dynamic nature of coping and health management means that different strategies should not be considered good or bad in isolation, but that their adaptiveness and usefulness be evaluated in context. Factors such as time also affect coping and management, for example, as strategies which are effective at the outset of an illness may not be so effective later, and Folkman and Moskowitz (2004) suggest that narrative, qualitative techniques may be more sensitive in identifying individuals' appraisals and strategies for dealing with lifestyle changes recommended in CHD.

The four approaches covered in this literature review recognise the importance of interpersonal relationships, but the theories and models struggle to account of the social, emotional, cultural, environmental, and economic factors which may affect both CHD and relationship functioning (Clark, DesMeules, Luo, Duncan, & Wielgosz, 2009; Coyne & Smith, 1994). A broad literature has explored interactional styles and interpersonal factors, but Bradbury and Karney (2004) draw attention to the pressures that socioeconomic circumstances may place upon couples

and which are rarely examined in detail in relationship research. Certainly, financial and employment factors were more influential than medical advice and information in a patient's decision to attend cardiac rehabilitation according to Clark et al. (2012), while Chan, Gordon, Chong, and Alter (2008) report that socioeconomically disadvantaged patients had greater CHD risk, and were less likely to make lifestyle changes, such as regular exercise, than those of higher SES, while people living in neighbourhoods with fewer resources to support a healthy diet and exercise also have higher levels of CHD (Wing et al., 2016).

Although research on ambivalence is beginning to recognise that positive and negative emotions and functioning can co-exist in a relationship (Uchino et al., 2013; Uchino, 2013), categorisations of relationship type and quality emphasise diversity between rather than within relationships. Designating relationship and communication styles as positive or negative can fail to take account of the complexity and multiplicity within a couple's relationships and interactions. The research takes for granted a contemporary view of coupledness as physically and psychologically therapeutic, but there is a lack of literature that conceptualizes relationships and health as multifaceted constructs in ways that do not categorise, idealise, and pathologise particular types of intimate relationships and behaviour (Campos, 2015).

Pathologisation and stigmatisation may be re-enacted by research and discourses that perpetuate more and less valued ways of being, which idealise consistently positive and supportive relationships, and problematise those that may involve conflict or criticism. This means that research itself can impact on how couples experience health, since assumptions that relationships may contribute to ill health as well as being responsible for health benefits may stigmatise or elicit self-blame in those who experience illness and/or difficulties in their relationship (Law & Urry, 2004). With the exception of attachment theory, the concepts of love and health are generally under-theorised in research into couples and health. Quantitative and qualitative papers rarely establish a clear definition of love, marriage, long-term relationships, taking for granted the objective nature of scientific enquiry, without interrogating current, socio-historically situated understandings of relationships (Illouz, 2007). What constitutes a positive relationship may seem intuitive, based on

social and scientific understandings of love as a universal, biological, evolved state, but Beall and Sternberg (1995) argue that relationships and communication are socio-culturally and historically constructed and situated. Different cultures and generations may not value or enact the same ways of being in long-term relationships as those presented in mainstream medical and health psychology research (Campos, 2015).

In their critique of broad and diverse ways of conceptualising and measuring health communication in couples, Goldsmith and Miller (2014) point out that measures are based on and tap into culturally available ways of understanding relationships, communication and illness. Research itself can contribute to the normalisation and idealisation of communication characteristics such as openness, which risks pathologising alternative communication behaviours and styles. For example, if good communication is understood to be a requisite for good relationships, then a participant with high relationship satisfaction is likely to report that their communication is also good. Questions relating to openness, for example, take for granted that it is a positive communication skill, but it is also a factor in measures of relationship quality and satisfaction, entangled in cultural values and lacking in specificity about how open communication might be constituted, and how it might be enacted in intimate relationships. The authors suggest that research is needed that provides more detailed and specific accounts of what and how couples talk about when they talk about health and illness.

Selection bias may also affect the findings of quantitative and qualitative studies of couples' health. Among those who give consent to take part in an observational study, participants are more likely to already have a healthy lifestyle, to have already received successful medical interventions, and to be receiving optimal treatment for current risk factors (Buckley, Murphy, Byrne, & Glynn, 2007). It is likely that similar processes affect recruitment to studies examining intimate relationships, as those whose relationships meet social norms may be more comfortable with the relationship coming under scrutiny.

Qualitative research explores some of this complexity through couples' subjective experiences of ill-health, as I will explore in the following section.

3.2 Qualitative Perspectives.

Patients' values and personal experience relating to lifestyle factors also form barriers or facilitators to their engagement in health behaviours (Murray et al., 2013). Qualitative studies therefore take descriptive or interpretative approaches to examining couples' experiences of lifestyle change in the context of CHD, using thematic and interpretative phenomenological analysis to present aspects of couples' experiences which are not readily accessible to quantitative measurement. In this section, I give a brief overview of common themes and some key studies in qualitative literature that focuses on patients and partners with CHD, to explore what these approaches add to understandings of couples and health. There are three major themes in qualitative research can be broadly mapped under the headings Interconnectedness, Dilemmas and Conflict, Communication, and Time.

Interconnectedness.

Just as the quantitative literature assumed a shared concern among couples for each other's health, the qualitative literature also reflected the interconnectedness of couples' health practices. In an early study of qualitative data, Radley and Green (1985, 1986) and Radley (1988; 1995) explored how couples negotiate illness in the context of heart disease. In a mixed-methods analysis of questionnaire and interview data from men awaiting CABG and their partners, the authors argued that adjustment to surgery was dyadic, in that couples negotiated not only their own, but also each other's different ways of coping. Using Herzlich's (1973) existing framework of adjustment styles, Radley and Green categorised patients' and partners' responses as either accommodation, active denial, secondary gain, and resignation. Within this conceptual framework, accommodation was considered positive and adaptive in that it acknowledged the limitations and changes that the diagnosis and prospective surgery brought, both in the present and future, while active-denial was considered less adaptive, characterised by a limitation or refusal to recognise the impact of the diagnosis on current and future functioning. In contrast, secondary gain was characterised by a recognition of positive change brought about by the diagnosis. Resignation was less affirmative than accommodation, and was characterised by a passive acceptance of the limitations of the illness, and a dysphoric response. Radley

and Green (1985) concluded that the efficacy of patients' coping strategies was less related to their physical symptoms, than to the ways in which their partner's and their own style of adjustment are entwined. Sperber, Sandelowski, and Voils' (2013) echo Radley and Green in their findings that couples who framed their health practices as cooperative, those who talked about 'functioning as a unit' (p.212), had greater reductions in cholesterol than those who expressed more individualistic approaches to health.

In his influential book *The wounded storyteller*, written after his own diagnosis with CHD, Frank (1995) identified three main narratives in responses to heart disease: restitution narratives, which involve a return to previous life and functioning; chaos narratives, where past certainties and illusions of control are lost; and quest narratives, in which the illness is the starting point for transformative processes. Radley and Green's (1985, 1986) use of Herzlich's coping styles was a precursor to Frank, and Arenhall, Kristofferzon, Fridlund, Malm, and Nilsson, (2011) echo Frank's narratives in couples' accounts of their diagnosis as a brush with death that necessitated lifestyle change. Participants recounted their illness as transformative, bringing them closer, as a threat that evokes fear, and as a missed opportunity to change as things return to 'normal'. A diagnosis of CHD appears to affect both partners in a couple, with complex and variable responses. These include changes to gendered caring and household responsibilities, engagement in lifestyle change, changes to their sex life, and also a reorientation of their lives around values such as fun and enjoyment, and living life to the full (Arenhall et al., 2011; Dalteg, Benzein, Fridlund, & Malm, 2011).

Qualitative research indicates that not only do couples cope jointly with the diagnosis and recovery from CHD, but that their psychological response is also jointly negotiated. Couples may share harmonious or experience conflicting responses to their illness, accounting for the possibility for affirmative but also negative health interactions and outcomes.

Dilemmas and conflict.

Qualitative research, however, in line with quantitative findings, reports that not all partner interactions are supportive. Shared social habits related to eating,

smoking and drinking alcohol may make it difficult for the patient to follow lifestyle advice after diagnosis with CHD. Cole, Smith, Hart, & Cupples (2013) carried out qualitative interviews with people with a diagnosis of CHD who had previously taken part in an unsuccessful lifestyle intervention (Murphy, et al., 2009). The participants identified a wide range of factors that affected their engagement in lifestyle change. Facilitators included social support, but participants reported that partners and friends could fail to support the adoption of healthier habits by viewing a return to previous behaviours, such as drinking, as a return to health and normality.

The finding that intimate partners can support but also undermine lifestyle change is echoed by MacLean et al. (2014), who found that female partners' response to lifestyle change could vary, from supportive to uninvolved in and undermining of men's attempts to lose weight. Some female partners purportedly experienced anxiety that a newly slim partner might be more attractive and attracted to other women. Köhler, Nilsson, Jaarsma, & Tingström (2016) also identify variability in how spouses respond to a partner's diagnosis of CHD. They designate partner responses as participative, regulative, observational, incapacitated (inability to be supportive), and dissociative. These roles were not consistent or stable, but could vary according to the situation, and the authors attribute these less engaged roles to a lack of understanding of medical and lifestyle information. While the authors identified categories of responses, people moved fluidly between these categories, indicating the dynamism, fluidity, and complexity of couples' health behaviours.

Negative emotions and hope were salient in Köhler et al.'s (2016) interview study, as patients and spouses feared relapse or recurrence of their CHD through over-exertion or other causative risk factors, and shared beliefs that new, preventative habits would be protective. There were correspondences but also divergent beliefs about the barriers to lifestyle change, including commitment to exercise regimes, for example, or fatalistic beliefs about the body's ability to heal itself. Partners were more likely to fear over-exertion, while patients were keener on a return to normal functioning (Köhler et al., 2016). Stewart, Davidson, Meade, Hirth, and Makrides (2000) also found that lifestyle changes relating to diet, exercise, activity and smoking could become sources of conflict for couples, and

spouses in particular can struggle with advice and information, for example, about low cholesterol diets. Stewart et al. (2008) also identify a lack of support for spouses in this process, despite the acknowledged importance of partner support to patient recovery.

Rather than simple designations of interactions or responses to illness as positive or negative, a key interview study that focused on how couples talk about lifestyle change indicated that lifestyle communication and interactions could produce dilemmas for couples (Goldsmith, Lindholm, and Bute, 2006). Firstly, partners were aware of a need to talk to their spouse about lifestyle change, but also that such talk could threaten valued identities by implying criticism or undermining patients' autonomy. Patients would resist the implication that they lacked understanding and the 'virtue' which is attached to both knowing and doing the right thing. But a further dilemma arose because partners avoidance of talk about lifestyle change could also be interpreted negatively as a lack of normative care and engagement. Talking therefore not talking risked being perceived as uncaring or uninvolved, while intervening could be rejected by the partner with CHD as infantilising. And finally, talking about lifestyle change, although perceived as key to recovery, also served as a reminder of their illness, which patients and partners were keen to put behind them.

Communication.

My own experiences as a carer for someone making lifestyle change after a diagnosis of CHD highlighted the importance of language – what could be said and not said, and the implications for identity of wider understandings of personal responsibility for health and ill-health. Some qualitative studies also affirmed the salience of language in couples' health interactions. Although they did not take a discursive or critical approach, qualitative studies highlight the costs and benefits of talk about health and lifestyle, and indicate that couples negotiate dispreferred identities in the context of a moral dimension to lifestyle management. Goldsmith, Bute, & Lindholm (2012) identified communication strategies used by couples where a partner had CHD that point to these complexities. These strategies included limiting talk on lifestyle change; 'saying it nicely' (e.g. by hedging, indirectly

addressing the issue or framing advice/criticism positively and/or tentatively); performing ‘routinized exchanges’ (repeated admonitions or warnings were taken by the partner/patient to be expressions of caring); using humour; and using cooperative and joint terminology to redistribute the power away from the person giving advice or exerting control. Both studies thus indicate that health communication is intricate and affects the functioning of the relationship as well as health behaviours.

Although Radley and Green (1985, 1986) did not link their findings explicitly with wider discourses, nor take a critical or discursive approach, some of their findings point to healthism and risk awareness which had implications for patients’ identities. For example, patients talked about personal responsibility for the cause of their disease (through smoking and diet, for example), but also for their recovery. Health identities and medical information about the patients’ conditions could be accepted or rejected by the patients and partners. The management of information was also something that changed throughout the process of diagnosis and treatment, with sometimes a resistance to too much information, or hearing about the severity of their disease, while at other times participants strongly expressed desire for more information and answers to questions about their diagnosis, treatment, recovery, and risk. This work highlighted changes to valued identities through illness, with patients working to present coherent, positive ‘morally creditable’ selves in the wake of their diagnosis and surgery (Radley & Green, 1986; Radley, 1996).

Time.

Radley (1996) also briefly considers the importance of time in couples’ adjustment to illness, noting that their ‘present was given its specific form through the anticipation of a particular future. That anticipation was, quite literally, lived out by them...how they, and their spouses, lived their lives, on how they oriented themselves toward any and every aspect of their daily existence’ (p.127). Time here is not a minor, extraneous factor, but central to couples’ adjustment to their diagnosis of CHD. Adding to the complexity of multiple time frames of illness and recovery, patients’ experiences may not be shared or in harmony with those of their partner. Couples in Radley and Green’s study experienced high levels of anxiety, and

variation in the timing of each partner's worries, producing both negative and affirmative experiences and responses, and highlighting the unpredictability of these interactions and the consequent coping and functioning of patients and their partners. Radley (1996) points out such divergences between partners in their evaluations and response to diagnoses, treatment, and recovery, further complicates an already intricate set of relations between patients, health-care providers, coping, and recovery. Barnett, Guell, and Ogilvie (2013), for example, found that older couples often shared attitudes towards an active retirement, but although the support of a partner was considered important for starting and maintaining exercise, their attitudes towards and engagement in exercise were independent and of long standing. Time is the least-explored aspect of how couples manage healthy living and lifestyle change, but as with other aspects of couples' shared health practices, there is potential for affirmative support, but also for increased complexity and possibilities for conflict in couples' differing perceptions of time.

Summary and limitations.

In summary, qualitative findings present healthy living as relational, and demonstrate the complexities of couples' health communications, as engagement in each other's health has the potential to produce conflict as well as fulfil expectations of supportiveness. Qualitative findings also highlight the importance of social and relationship norms, which form the context to material and physiological aspects of illness and health. Partners may undermine as well as support attempts at lifestyle change, and couples negotiate a range of emotional responses to lifestyle change and illness which adds to the variability of their responses and coping. Socio-economic factors, such as returning to work, also impact attempts at lifestyle change after CHD, anxieties and practicalities which couples manage together. Couples manage each other's understandings of risk, and fear of recurrence also has the potential to cause anxiety and conflict. Couples can respond to CHD and the consequent need to make lifestyle change in different ways, from experiences of fear and risk, to perceptions of a new beginning that brings them closer together. One partner's diagnosis of CHD appears to affect both people in an intimate relationship, with complex and variable responses. They may experience increased anxiety and feelings of vulnerability, changes to gendered caring and household responsibilities

and engagement in lifestyle change, resuming their sex life, and also a reorientation of their lives around values such as fun and enjoyment, and living life to the full (Arenhall et al., 2011; Dalteg, Benzein, Fridlund, & Malm, 2011).

The qualitative studies discussed here point to the complexity and also the fluidity of couples' health interactions, and reflect the variability that is found in the quantitative literature (e.g. Robles et al., 2014). The theme of interconnectedness reflects the normativity of couples' involvement in each other's health and lifestyle, and the possibility of both affirmative and negative experiences relating to their shared experiences. The theme of dilemmas and conflict highlights the negative potential for couples' health interactions that again, echoes findings in quantitative studies (Kim & Waite, 2014; Tucker & Anders, 2001). Qualitative studies also indicate the importance of language and communication to couples' health practices which is not explored in any detail in the quantitative literature. Finally, changes over time in coping strategies and styles and the salience of future hopes and fears in present behaviour and talk indicates that couple health interactions are not solely predicated upon stable states and traits, but suggests the fluid, relational, contextual nature of couples' health practices.

Although qualitative approaches demonstrate considerable nuance and complexity in factors such as interconnectedness, conflict, communication, and temporal fluidity, the literature does not fully engage with or theorise the wider social factors that are implicated in couples' health practices. Power relations exist on a macro as well as on a micro level, but neither the qualitative or quantitative literature described in this review conceptualises the play of power relations between government institutions, commercial forces, medical experts, and lay people, and between partners attempting to influence and control each other's health. In particular, they lack a theoretical basis for examining the power of social discourses to establish dominant knowledge and understandings of health, and to shape what can be said, thought, and felt in relation to health and healthy living.

In chapter 2, I examined critical perspectives on health, which apply Foucault's notions of power and governmentality to the current global focus upon health and lifestyle. Critical engagement with the intersection of health and intimate

relationships forms a much smaller literature, but in the section below, I explore coupledness from a critical perspective, and present critical studies of couples and health.

3.3 Critical Perspectives on couples, health, and lifestyle change

Critical approaches that draw on poststructuralist or social constructionist epistemology challenge the assumptions of positivist approaches that underline the quantitative health research on intimate relationships described above. Critical insights locate conceptualisations of love and health within a socio-historical context rather than assuming them to be universal truths, and to attend to the power relations that are created and perpetuated both through social, and scientific discourses (Hook, 2001; Fairclough, 2001; Rose, 1999). Instead such critical approaches consider how identity, gender, and intimate relationships rather than being innate, biological or essential, are performed and reinforced through social discourses and practices (Butler, 1990; Henriques et al., 1984). In chapter 1, I outlined my search for a definition of love that encompasses both its affirmative and negative potential without perpetuating stigmatising judgements and categories. This search was important because I see the logic that healthy relationships are good for physical and mental health, which underpins much of health research, can position relationships as dysfunctional when illness or resistance to lifestyle change occurs. I see a parallel therefore between Willig's (2011) argument that healthism creates the context in which the cancer sufferer is blamed for their cancer, with health psychology models creating the context for people to understand their or their partners illness (or poor recovery of illness) as located in their failure to have good relationships with their intimate partner. Poststructuralist informed critical psychology used concepts such as healthism and governmentality to identify the logic of blame inherent in mainstream biomedical, health psychology, and health promotion discourses. How then might it help this thesis in developing an alternative framework that did not reproduce stigma regarding ill health? This question I address below by presenting key critical perspectives relating to intimate relationships, which provide concepts and insights that illuminate aspects of couples' health practices, which focus on love, normativity, gender and power.

Intimate Relationships and Love.

Love has been a problematic subject for both mainstream scientific and critical and feminist study. From a positivist perspective, love is an emotive, ineffable state that does not lend itself to rigorous inquiry. The outcome is that while couples' care of each other's health is a major research focus, this research rarely mentions love. Love is thus silently present in research into aspects of love such as care and nurturing (Toye, 2010). For poststructuralist-informed researchers, love is often associated with conservatism and hegemonic, gendered relations. Consequently, romantic love's potential for oppression and unequal power relations between romantic partners is more strongly represented in critical and feminist literature than more affirmative conceptualisations and experiences (Fraser; 2003; Illouz, 2011; Jackson, 1995; Toye, 2010). In mainstream health psychology either love's functional, adaptive, and biological nature is emphasised, or love is absent, while in critical approaches, love is problematized.

Critical approaches to love encompass diverse and paradoxical meanings in modern times, and conceptualise love as socially constructed and performative (Gergen, 1999; Butler, 1990, 1993), enacting gender, emotion, and reproducing social orders. Social constructionist perspectives encompass its variability and multiplicity, performativity, and sociohistorical and cultural situatedness (Beall & Sternberg, 1995). Giddens (1992) identifies a contrast between older concepts of romantic love as a social contract and contemporary love as what he 'pure love'. Rather than being entered into to fulfil social expectations, contemporary love is an individualistic phenomenon, 'entered into for its own sake, for what can be derived by each person from a sustained association with another; and which is continued only in so far as it is thought by both parties to deliver enough satisfaction for each individual to stay within it' (p.58). Critical researchers point to the rationalisation of love that is the outcome of Giddens' 'pure love'. Individuals now expect relationships to lead to self-actualisation, personal growth, and deep emotional connections (Illouz, 2007).

For Illouz and Giddens, contemporary conceptualisations of love fit within neoliberal discourses of equality and self-growth, and reinforce understandings of intimate relationships as therapeutic. Love plays a part in 'the new therapeutic

culture' in which a 'model of health that massively penetrates intimate relationships demands that love be aligned along definitions of wellbeing and happiness and submitted to the iron law of utility' (Illouz, 2010, p.25). In the context of lifestyle behaviours and change, understandings of love as therapeutic are played out in discourses of partners' roles in each other's physical health as well as psychological well-being. In this process, they argue that it is demystified and quantified, but despite this rationalisation, pragmatic and romantic aspects of love are still intertwined. In postmodern times, meanings and identities are cumulative rather than successive, so that couples may negotiate multiple, competing and sometimes conflicting norms in their intimate relationships (McRobbie, 2004; Toyne, 2010). Intimate relationships are therefore sites where partners work on their physical and psychological health, but where other norms and ideals of romantic relationships may also have to be negotiated.

Critical approaches also afford a perspective on the implications of mainstream evolutionary and psychobiological approaches which take a utilitarian view of love as an evolved emotion and that parental and romantic relationships bestow a survival advantage on offspring and parents. Implicit and explicit evolutionary understandings of romantic relationships can reproduce cultural discourses, such as beliefs that women and their children benefit from their investment in partner and child attachments, while men's evolutionary imperative is to father as many offspring as possible, reducing the value of love and commitment for men (Buss, 2009). Evolutionary research draws on and reinforces dominant, stereotypical understandings of gender, rather than looking at variability within as well as between genders, and alternative explanations for equivocal findings. Evolutionary explanations for adaptive mating behaviour appear plausible, but similar explanations are sometimes used to explain very diverse functioning. For example, pair bonding is described as adaptive for both men and women, but non-monogamous behaviour is also presented as advantageous for men. Reductive theories allow normative, heterosexual relationships to dominate understandings of love through evolutionary, biological, and utilitarian approaches that reinforce imperatives of heterosexual mating and reproduction (Law & Urry, 2004; Toyne, 2010).

Normativity, gender, and power.

Bringing intimate relationships together with health, Rose (1999) proposes that families have been constructed as a 'vital commodity for the purchase of good health, well-being and a securitised freedom' (p.270), he implies that intimate relationships may also be sites of health practices that produce reproduce appropriate health subjectivities. Finn (2005) also applies Foucault's concepts of disciplinary power and normalisation to contemporary understandings of love, in which monogamous, securely bonded relationships are constructed as 'healthy', and other ways of being single or partnered are pathologised. Similarly, Ahmed (2010a) argues that happiness is normalised through the pathologisation of sadness and conflict, such that particular styles of intimate-partner relationships have been established as biological and social norms from which difference deviates in a pejorative way. Stability, truth, authenticity, and security are sought-after states, and ones which find their full expression in a 'healthy' relationship. Finn (2005) argues that such discourses of coupledness regulate the limits of what a relationship should be, and prescribe and normalise the conduct of its partners. Intimate relationships may therefore be seen as highly over-coded spaces, with 'scripts, rituals, institutions, and conventions through which couples' possibilities are simultaneously formed, enabled and constrained' (Finn, 2005, p.273).

Norms are also important in caring aspects of intimate relationships Gregory (2005) examined the performativity of family and intimate relationships through health and diet-related practices. She used Giddens' (1992) notion of 'ontological security', Giddens' term for people's striving to achieve and maintain desired personal identities and sense of coherence, stability, and security, to understand normative family interactions in patients with CHD or coeliac disease (a gastrointestinal condition that requires dietary management). Gregory's thematic analysis indicated patients' identities as healthy or ill are co-produced with families and partners.

Critical approaches draw on the notion of gender performativity, constructing gender as produced through repetitions of behaviours in line with gendered norms (Zimmerman & West, 1987; Butler, 1993). Several studies apply the notion of gender

performativity in the context of couples' management of illness. For example, Gregory (2005) reported that illnesses could affect and disrupt gendered family roles, though an element of the normality that families strive for involves maintaining or resuming previous patterns of domestic and family work, in patterns that reinforce norms of gendered and family caring. Seymour-Smith and Wetherell (2006) suggest that in couples' co-construction of illness narratives, women open up discursive spaces for men, freeing them from hegemonic masculine identities to access emotions and health practices. The authors identified these 'interactional gifts' as facilitated by women, but not male partners.

Similarly, Mroz et al. (2011) report heteronormative, gendered patterns in the buying and cooking of food, and in women's compliance with recommended dietary changes in their study of couples making changes to male partners' diet after diagnosis with prostate cancer. These patterns reinforced notions of women as carers and as exercising control over a partner's diet and health behaviours, but the authors located women's control in the context of wider, gendered, sociocultural, and socioeconomic power relations. The authors of both studies concluded that women's practices reinforce gendered patterns of male dominance in that women were instrumental but subordinate in their facilitation of male partner's health practices. although in Both studies only involved male patients and female carers. Because prostate cancer only affects men, there were no data from couples where the woman was the patient with a male carer, so it is not known what patterns would emerge in conditions in which both men and women can be patients and carers, and the extent to which apparently gendered patterns are related to those roles.

Critical literature engages with how wider social discourses are folded into individuals' and couples' health practices. Foucault's notions of disciplinary power provide conceptualisations of how power relations circulate between individuals and social institutions such as medicine and health promotion, as well as between partners as they engage in shared practices of healthy living and lifestyle change. Understandings of love as socioculturally and historically situated broaden the focus from biological, functional, reductionist views of intimate relationships. Illouz (2007) and Giddens (1992) locate intimate relationships within contemporary therapeutic culture, whereby people are brought to work on themselves in a process

of self-improvement. They therefore offer a perspective on the affinity of love and health, and thus contribute to the notion that control is at the heart of modern conceptualisations of love. The concept of normativity accounts for the ways in which people try to maintain positive identities, and position themselves favourably in relation to dominant discourses, and points to the potential for multiple norms, such as those of intimate relationships and of health, to compete and conflict as well as align. Critical approaches also highlight how biomedical and health psychology research structure understandings of what constitutes an ideal relationship or a good health citizen, and can therefore categorise, pathologise, and stigmatise individuals and couples who do not meet norms and ideals.

Limitations of the Literature.

While critical approaches do address issues of social norms, gender, and disciplinary power in intimate relationships, there is a lack of a clear definition of love within the critical literature that accounts for its affirmative as well as negative possibilities (Toye, 2010). Critical approaches, as discussed in chapter 2, draw attention to the ways in which social norms of health are enacted in repressive ways. But Foucault (1980) acknowledged that power is productive and can be affirmative as well as negative. As with love, a theorisation and definition of health also needs to encompass affirmative experiences of physical exercise, for example, as well as the capacity for neoliberal health discourses and institutions to produce negative subjectivities.

The logic of lifestyle-disease discourses is that those who do not make choices to avoid poor health outcomes are positioned as both irrational and irresponsible. Similarly, for couples who are designated as unsuccessful in supporting each other to make appropriate lifestyle choices, both within the absence or presence of illnesses such as CHD, there are implications of failure and blame. A theoretical framework is needed that does not draw on notions of dysfunction and deficit in order to account for the ways in which intimate relationships may be both beneficial and detrimental to health, but which accounts for the complexity and dynamism of both relationships and health, and which questions assumptions that the two will naturally be in alignment. There is currently a gap in the literature, with an

absence of studies that use a discursive, poststructuralist approach to explore how couples manage healthy living and lifestyle change.

3.5 Rationale and Research Questions for Studies 1 and 2.

In this chapter, I explored approaches to intimate relationships and health that focus on couple interactions, social support, interdependence and social control, and those that focus on inherent relationship characteristics, such as attachment style and relationship quality. These approaches and theories offer different lenses through which to understand intimate relationships and health. Their wide variety indicates the complexity of conceptualising both intimate relationships and health, but no one theory or perspective accounts for the variability and dynamism of psychological, social, interpersonal, and physiological factors upon health within intimate relationships.

The common ground that exists between the different approaches outlined in this chapter indicates additive rather than mutually exclusive aspects of intimate relationships and CHD, a multiplicity that also needs to be accounted for within a broader conceptualisation of how couples manage health practices. Across a range of approaches, health is acknowledged to be a complex construct, with biological, environmental, individual, interpersonal and social dimensions, including the wider discursive context in which couples are located, particularly in light of the powerful social discourses of health that are discussed in chapter 2. Currently, there is no research that takes a critical, discursive approach to couples, health and lifestyle, or accounts for the ways in which couples must jointly negotiate wider social understandings and discourses of health, in the context of inescapable discourses of lifestyle as preventative and curative of illness which shape contemporary sense making around health. Research is therefore needed that locates couples within their wider discursive context, particularly in relation to lifestyle advice. The logic of blame inherent in neoliberal discourses of responsibility for health drives a need for research that is ethical in its sensitivity to the potential for harm in psychological research on couples and health (Lupton, 2014; Thompson & Kumar, 2011).

To address these needs, the current thesis proposes and applies a poststructuralist, affirmative approach to understanding health negotiations within

long term relationships. In so doing, this thesis aims to address an important gap in research and contribute to current debates about health and lifestyle in the context of long-term relationships, both in health and illness, using the context of a ‘lifestyle disease’, CHD, as an example. To explore the ways that people in long-term relationships talk about and manage healthy lifestyle and lifestyle change, the following research questions form the basis of this thesis, and for a more complete and affirmative conceptualisation of the dynamics of both relationships and health:

1. How do people in long-term relationships talk about and manage health, lifestyle and lifestyle change advice in both health and illness (using CHD as an example)?
2. Can a Foucauldian-Deleuzian theoretical framework account for and offer new perspectives on the variability and complexity of health behaviour within long-term relationships?

In the following chapter, I start to address Research Question 2 by offering a theoretical framework for thinking about relationships and health, and which provides a basis for methodologies to explore variability and dynamism, affirmative as well as negative health and relationship interactions as couples negotiate wider social understandings of both intimate relationships and healthy lifestyle.

Chapter 4 Theoretical Framework

Introduction.

In this chapter, I examine the poststructuralism of Michel Foucault, Gilles Deleuze and his collaborator Felix Guattari, and identify the implications of their philosophies for understanding health, power relations and subjectivity. Their ideas have informed a range of approaches and methodologies in the social sciences and humanities, and I explore how they may be applied to both health and intimate relationships. The starting point for this thesis was the question of how to conceptualise couples' engagement and non-engagement in lifestyle change in a way that accounts for how health information is taken up and resisted, as well as for affirmative and negative interactions and outcomes in couples' health interactions. In chapter 2, I discussed the potential for blame in neoliberal discourses of personal responsibility for health and scientific discourses that trace linear causal relationships between illness and lifestyle behaviours. I therefore sought an ethical approach to researching health-related behaviours that avoided the potential of research into lifestyle and couples to be reductionist, stigmatising or judgmental.

Law and Urry (2004) argue that knowledge and power are central to health and health behaviour, and that a critical approach allows a mapping of the ways that dominant understandings and discourses of health are negotiated by people in their health practices, forming part of, constraining, but not determining their embodied, relational experiences. The philosophy of Michel Foucault has therefore been applied extensively to the study of health, and below I discuss his concepts of power and knowledge, and consider how they might illuminate couple health interactions. Although Foucault is known for his mapping of the negative ramifications of disciplinary power in relation to discourses of health and medicine, his ideas also encompass more affirmative aspects of power, and the ways in which such discourses have material and embodied dimensions, but it was his contemporary Gilles Deleuze and Deleuze's collaborator, Felix Guattari, who developed a fuller and more affirmative philosophy. Their metaphysics, a philosophy that accounts for human experience of the material and nonmaterial world (Braidotti, 1993; Barad,

2003), offers the possibility of an affirmative ethics that informs understandings of relational health behaviours in a complex, fluid, postmodern world (Duff, 2014; Fox, 2005).

4.1 Foucault, Power, Knowledge and the ‘Discursive Turn’.

Foucault’s philosophy provides a framework for thinking about social structures and relations. His conceptualisation of power as a primary force, and its indivisible relationship with socio-historically situated knowledge, forms the basis for critical analyses of the regulatory functions and practices of social and human sciences, especially medicine, psychiatry, and psychology (Foucault, 2003; Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998; Rose, 1999). Below I discuss his concepts of power, knowledge, and discourse, and consider their potential application to couples’ health practices.

Power, knowledge and discourse.

Foucault’s conceptualisation of how the social shapes individuals involves a process ontology that encompasses his theory of power and subjectification. He affirmed that rather than prior, stable individuals who undergo experiences that shape their identity, subjects are produced by subjugating and subjectifying social forces and processes:

a form of power that makes individuals subjects. There are two meanings of the word subject: subject to somebody else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both means suggest a form of power which subjugates and makes subject to (Foucault, 1982, p.781).

Foucault thus accounts for the ways in which people are shaped regulatory social forces, and by the internalisation of such norms which produce a sense of self and identity. Knowledge is inseparable from Foucault’s notion of power, since power relations are created through the privileging of particular kinds of knowledge over others. The inequality between dominant and subjugated knowledge shapes what is understood as legitimate knowledge and consequently legitimate behaviour. Of the indivisible relationship between power and knowledge, Foucault writes that,

‘Power produces knowledge...power and knowledge directly imply another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations’ (Foucault, 1977, p.27).

Certain knowledge, then, such as that produced by scientific and medical institutions, is held to have a greater claim to value and truth, creating power relations between dominant and subjugated knowledges. The different value placed on patient perspectives exemplifies knowledge ‘located low down on the hierarchy, beneath the required level of scientificity...unqualified, even directly disqualified knowledges’ (Foucault, 1980, p.82). In the tradition of scientific inquiry, the knowledge thus created is accorded the status of truth, which legitimises social action and order. In this way, power and knowledge are productive of more and less privileged subject positions and social disparities. Foucault’s insight was that such truths are not universal and objective, but contingent upon ‘rules that come into play in the very existence of such a discourse’ (Foucault, 1970, xiv). He argues that knowledge itself is not universal, cumulative, and linearly progressive, but rather characterised by changes and discontinuities that indicate its historical and socio-cultural situatedness.

Foucault distinguished between two types of knowledge. *Connaissance* refers to a formal body of knowledge, such as medicine or biology, and the rules that govern it, while *savoir* is the knowledge jointly produced and productive in interactions with others, socially constructed knowledge that is ‘active and captures a subject’s process of modification and transformation’ (Jackson & Mazzei, 2012, p.50). Knowledge therefore produces broad normative forces, such as the disciplinary power and governmentality outlined in chapter 2, but also diffuse, local, and reversible power relations. Power circulates as people adopt, resist, or transform knowledge which means they can simultaneously be both subject to and transmit power:

Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the

position of simultaneously undergoing and exercising power' (Foucault, 1992, p.98).

Foucault's notion of power, then, is not of a force that is possessed or exerted in stable, linear ways, but is indivisible from knowledge, forming a shifting set of relations between individuals, as well as between individuals and wider social discourses and institutions.

Foucault used the term discourse to encompass the rules and practices as well as the language that shape what people can do, think and say in relation to health. A discourse of healthy living, for example, 'defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about...how ideas are put into practice and used to regulate the conduct of others' (Hall, 2001, p.72). Discourses of health are constitutive of subjects, delineating the boundaries of recognisable identities and categories. Subjects are formed through the 'reiterative power of discourse to produce the phenomena that it regulates and constrains' (Butler, 1993, p.2), Health, for example, like gender, is not a quality possessed by a body, but 'one of the norms by which the "one" becomes viable at all, that which qualifies a body for life within the domain of cultural intelligibility' (Butler, 1993, p.2). A diagnosis of mental or physical illness shapes how people identify themselves and are identified by others. The diagnosis also has material consequences as it legitimises the ways in which people are treated, socially and medically.

Hall (2001) argued that Foucault was clear that discourse has material dimensions and consequences, and stated that the relationship between materiality and discourse is that, 'physical things and actions exist, but they only take on meaning and become objects of knowledge within discourse' (p.73). Discourse is thus inseparable from actions, objects, and embodied practices. Knowledge, power and discourse are all relational, and Foucault was interested in the ways in which people understand and transform themselves through expert and social discourses (Foucault, 1980). In a health-focused society, health is a major norm through which people understand and value themselves and others (Crawford, 1980).

Normativity.

Norms are understood as recurring patterns whose typicality is assumed to represent an underlying natural order. It is this assumption that contributes to a moral dimension to normalisation, and enables it to function as a form of disciplinary power and shape our desire to achieve valued ways of being (Butler, 1993). Neoliberal discourses work ‘on and through desire’ (Davies, 2013, p.28), such that imperatives of health produce desired identities; in fulfilling those imperatives, people come to feel they are fulfilling their own desires and potentials (Massumi, 2003). Normalisation works externally, as social institutions and practices reinforce normal and idealised ways of being, but also internally, as such norms become folded in to consciousness, and structure the way we understand ourselves and others (Butler, 1993; Foucault, 1988). Bronwyn Davies (2013) explores the implications for agency, as the ‘illusion of autonomy’ (p. 24), especially in neoliberal societies, impedes our registering the continuous reiteration of social norms, which gives an impression of stability and natural order. She argues that it is the lack of consciousness or insight into these processes that allows regulatory norms to evoke emotions such as:

‘longing’ for to be recognised ‘as a viable being...fear of non-survival, when the norms are disregarded or challenged...anger or disgust felt towards the one...who transgresses the norms and thereby risks destabilizing them; anxiety when falling short in terms of one or another norm; and joy either in moments of being recognized as a viable being, or in changing the norms through which we are recognized (p.24).

Forces of normalisation produce both intelligible subjects, but also ‘abject, unliveable bodies’ (Butler, 1993, p.xi), as processes that delineate normalcy simultaneously exclude those who lie outside the boundaries of what constitutes a viable, valued subject.

People are not simply passively produced by discourses of health. Resistance to, or the incomplete capture of bodies by regulatory norms can be productive of new discourses and reconceptualisations of bodies and subjects, as it is a power that undoes and deconstitutes as well as constitutes (Butler, 1993). At the edges of

normative subjecthood, disqualified identities reinforce, but can also challenge and undermine the boundaries of normality, producing an ongoing struggle for legitimacy, recognition, and value. Global concern about obesity, for example, is challenged by movements such as Health at Every Size, which works to de-stigmatise body size (Bacon & Aphramor, 2014). These processes can happen on a wider, social level, but are also enacted through interpersonal interactions as patients with CHD negotiate identities as healthy or ill, as carer or cared for.

Health.

Foucault's conceptualisation of power and knowledge has clear applications to the field of health and medicine, but also for exploring the ways that health discourses are enacted by individuals. Foucault (1980) captured the regulatory, coercive, beneficent, public, and private dimensions of health when he argued that a primary aim of government towards its citizens is 'to help and if necessary constrain them to ensure their own good health. The imperative of health: at once the duty of each and the objective of all' (p.170). Health is a site where power functions on a macro, but also on a micro level, as individuals 'enfold' dominant health discourses into their own embodied health practices, interactions, and identities (Smith & Tucker, 2015). Foucault distinguishes between 'technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject' (1988, p.18) and:

technologies of the self which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, p.18).

The relationship between technologies of power and technologies of the self are observable in contemporary discourses of health as achievable through healthy lifestyle, and healthy lifestyle as a personal responsibility and civic duty. Power is legitimised through medical knowledge, and exerted through injunctions to regulate diet and exercise. In this way, the ordinary activities of daily living move from the private to the public sphere, and government campaigns such as five-a-day, whereby

people are encouraged to eat at least five portions of fruit and vegetables a day (NHS, 2016), are enfolded into people's aspirations and embodied practices.

Foucault recognised the importance of bodies to disciplinary power, and argued that that biopower 'is centred on the body as machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and docility, its integration into systems of efficient and economic controls' (Foucault, 1976/1979, p. 139). This understanding of health permeates discourses of personal responsibility and civic duty, and accounts for the moral dimension present in neoliberal health discourses and for the abject health identities inhabited by those who do not conform to norms of health and health behaviour (Rose, 1999). The exclusion of smokers and those designated as obese from elective surgeries (Royal College of Surgeons, 2016) can be seen as a consequence of the logic of neoliberal health care, through which less deserving health identities are created and differentiation is enacted through restricted care.

Although disciplinary power functions through processes of normalisation and problematisation, Foucault by no means considered power to be invariably negative. Rather he saw it as a creative, productive force, and this mix of the benign, the affirmative, and the oppressive can be seen in the 'healthism' that pervades modern Western societies. The promise of the benefits of a healthy lifestyle are largely uncontested, and it is this promise as well as the fear of ill-health that make health discourses so powerful:

What makes power hold good, what makes it accepted, is simply the fact it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1980,p.119).

Individuals negotiate these power relations and norms, the affirmative and negative ramifications of the current intense focus upon health and lifestyle, but couples' involvement in each other's health mean that their negotiations are on another's as well as their own behalf. They manage health alongside the norms and discourses of intimate relationships, which Foucault also included in his theory of disciplinary

power and consideration of how the interpersonal and private come under the gaze and reach of governmentality.

Intimate relationships.

Foucault applied his concepts of power and subjectivity to intimate and sexual relationships. Just as medicine regulates and produces subjects as healthy or ill, human relations are captured and controlled by laws, rules, and customs, produced by and reproducing the social order (Finn, 2005; Rose, 1999). Foucault focused largely on sexuality as an object of disciplinary power, and also proposed that institutions such as marriage reproduce a hegemonic social order in the normalisation of heterosexual relationships (Finn, 2005; Finn & Malson, 2010; Foucault, 1992). Discourses of intimate relationship are thus regulatory, through which the limits of what a relationship should be and the conduct of its partners are proscribed and normalised. Intimate relationships are a highly over-coded space, with ‘scripts, rituals, institutions, and conventions through which couples’ possibilities are simultaneously formed, enabled and constrained’ (Finn, 2005, p.273), accounting for the potential of intimate relationships to be affirmative and productive as well as oppressive.

Although he wrote more about sexuality than love, Foucault argued that the regulation of love by disciplinary power impoverishes human relations, and he recognised the creative and subversive potential of love when he suggested that ‘[s]ociety and the institutions which frame it have limited the possibility of relationships because a rich relational world would be very complex to manage’ (Foucault, 1997, p.158). Foucault reflected that it was not the idea of homosexual sex, for example, that troubled society, but the possibilities that men could love each other that disrupted the social order. The power of love to create new possibilities is affirmed in Foucault’s statement that, ‘everything that can be troubling in affection, tenderness, friendship, fidelity, camaraderie, and companionship, things that our rather sanitized society can’t allow a place for without fearing the formation of new alliances and the tying together of unseen lines of force’ (Foucault, 1997, p.136). He anticipated the power of homosexual love to change society, through ‘the creation of new forms of life, relationships, friendships in society, art culture and so on through

our sexual, ethical and political choices' (1997, p.164), and advocated a broadening out of possible social relationships, dissolving mutually exclusive categories of love, sex, and friendship to encompass the varied and nuanced possibilities for affirmative human relations. So despite his criticism of institutions such as marriage, and his recognition of the ways power can operate in broad social as well as local, reversible ways within intimate relationships, Foucault nonetheless acknowledged love as an affirmative, creative, and potentially subversive force.

Foucault's philosophy of power, knowledge and language forms the basis for methodologies broadly referred to as discourse analysis, the study of the language, institutions, practices, and subjectivities that make up particular discourses and are reproduced by them, such as those relating to health and intimate relationships. Despite Foucault's emphasis on the performativity of discourse, and the inclusion of materiality, embodiment, and creativity in his concept of power, his philosophy and associated methodologies has been criticised for privileging linguistic over material aspects of experience, and for not fully theorising embodiment and emotion (Barad, 2007). His contemporaries Deleuze and Guattari developed an affirmative philosophy that conceptualises desire rather than power as a primary productive force, and which fully encompasses affective, embodied, material, discursive, and non-discursive aspects of experience. In response, Blackman et al. (2007) and Clough & Halley (2007) chart the 'affective turn', an application of the ideas of Deleuze and Guattari to more fully conceptualise human experiences.

4.2 Deleuze's Metaphysics and the Turn to Affect.

Deleuze drew on the philosophy of Spinoza, in particular his opposition to Descartes' hierarchical, anthropocentric, dualistic model (Deleuze, 1988; Brown & Stenner, 2009; Williams, 2003). In the dualism of mind and body that underpin Modernism, higher status was given to the mind, rationality, and especially to scientific knowledge as a source of objectively verifiable truths about the world, than to the body and the emotions, which the mind was assumed to observe, control and guide (Foucault, 1980; Gergen, 2001; Law & Urry, 2004). Within a transparent world order, individuals were considered to be cognitive beings, capable of autonomous, self-willed thought and action, independent of their sociocultural

setting (Thompson & Hirschman, 1995). Bordo (1993) maps the pervasiveness and normativity of mind/body dualism when she designates it as ‘no mere philosophical proposition to be defended or dispensed with by clever argument. Rather it is a practical metaphysic that has been deployed and socially embodied in medicine, law...the psychological construction of the self, interpersonal relationships, popular culture and advertisements’ (p.14). Dualism thus structures social institutions and individuals’ thoughts.

The consequences and impact of a Cartesian world view are also explored by Braidotti (2002, 2013), who traces the framework for contemporary power relations and hegemony. She argues that modern capitalism and neoliberalism share rational and utilitarian Cartesian foundations, and Descartes’ hierarchical world view is the source of the moral rules which guide human behaviour even in secular societies (Braidotti, 2002). Actions and constructs are considered right or wrong in relation to a moral hierarchy where humans differ pejoratively from God, aspire to God’s perfection, and are properly engaged in a process of self-improvement towards that ideal (Deleuze, 1988; Foucault, 1986). The science of human behaviour, while adopting scientific alternatives to religious and philosophical explanations of existence and experience (Davies et al., 2002), retains elements of this moral framework and basis for self-improvement (Thompson & Hirschman, 1995). According to Braidotti (2002), a Cartesian world view has historically enabled a sense of racial, gender and class superiority in educated, white, men of European heritage, justified practices that subjugated women, and non-white, non-European ‘others’, and which still underpins the power relations that circulate on a local and global level.

Mainstream, scientific, medical, and social understandings of the body are organised according to these tenets of modernism, with implications for the ways in which people understand themselves and others as healthy or ill, for example. In the following section, I consider the philosophy that Deleuze developed alone and with Guattari, based in part on Spinoza’s challenge to the assumptions of Cartesian positivism, and which offers a framework for rethinking reality and subjectivity. I will outline several key concepts in Deleuze and Guattari’s metaphysics, and which

together form the principles of a process ontology that can illuminate the processes involved in couples' health interactions.

Immanence and monism.

Rather than drawing on transcendent or divine entities or causes to account for existence, Deleuze adopted Spinoza's concept of immanence. According to Spinoza, there is a single substance that forms all existence and matter, folded into different manifestations and forms, both material and non-material. Nothing is external to this substance, in the way that God is conceptualised as an external cause by Descartes (Deleuze, 1988). Spinoza's monist philosophy thus rejected hierarchies and dualisms of human and divine, of mind and body. Spinoza argued that if thought were different from emotion or physicality, it would not be possible for the two to connect or to perceive each other (Deleuze, 1988; Eichner, 1982). Spinoza proposed instead a monist model, whereby substance forms into different modes, each of which has attributes of both extension (physicality), and thought. A human being can be considered as a body under the attribute of extension, and as a mind under the attribute of thought, but these attributes are parallel and indivisible, two sides of the same object (Deleuze, 1988). One implication of Spinoza's monism that is of relevance to the body and health is that there can be no cognitive or intellectual experience that is not also embodied, dissolving distinctions between mind, body and emotion, for example. Below I explore Deleuze and Guattari's (1987) conceptualisation of how immanent existence is rhizomatic and dynamic rather than stable and systematic.

Rhizome.

In *A Thousand Plateaus* (1987), Deleuze and Guattari contrast traditional, scientific and philosophical 'arboreal' thinking with their rhizomatic theory. In the first, hierarchical, tree-like structures shape a reality of linear causal relationships and dualistic categories that 'branch off' a common root and follow a deterministic system. Rhizomatic thinking, on the other hand, conceptualises a world of ever expanding and proliferating lateral, non-linear, multiple connections and relations. They draw analogies with the way that grass roots spread out laterally, interconnecting and forming multiple nodes and hubs, and argue that the human

brain also resists stratification into a rigidly organized system, as it consists of billions of plastic, interconnecting nerve cells. It is not organized hierarchically, but instead forms nodes and centres of specialization, giving rise to multiple consciousnesses (Zeki, 2001).

A rhizomatic reality is not governed by pre-ordained patterns and systems. Instead, it can be described as an ever-evolving series of processes that are constrained, but not determined by the conditions of possibility. The implications for the self and thought are that individuals (both human and non-human), rather than prior, bounded and stable beings are instead produced by these continuous, unpredictable connections and relations that actualise subjects and objects (Deleuze, 2001). I examine these processes below in a more detailed consideration of Deleuze and Guattari's concept of assemblages.

Assemblages.

Within proliferating, connecting rhizomes, an assemblage is a dynamic grouping of elements that form at the confluence of forces and elements such as bodies, technologies, politics, and economics. Assemblages form part of Deleuze's process ontology, since they are defined by their relations and dynamics rather than by their components. An assemblage 'is a multiplicity which is made up of heterogeneous terms and which establishes liaisons, relations between them, across ages, sexes and reigns – different natures. Thus the assemblage's only unity is that of co-functioning' (Deleuze & Parnet, 2002, p.69):

We will never ask what [it] means, as signified or signifier; we will not look for anything to understand in it. We will ask what it functions with, in connection with what other things it does or does not transmit intensities, in which other multiplicities its own are inserted and metamorphosed, and with what bodies ...it makes its own converge' (Deleuze & Guattari, 1987, p.2).

Deleuze and Guattari thus emphasise the performativity and productivity of assemblages, and they reframe traditional scientific inquiry about what things are into questions about how they work and what they do.

Deleuze and Guattari's (1987) use the concepts of deterritorialisation and reterritorialisation convey the dynamic processes of assemblages. They use an example of an orchid that resembles a female wasp and gives off a chemical similar to the pheromones female wasps use to attract mates. Male wasps are attracted to the flower, and attempt to mate with it. In the process, they are covered in pollen which they carry to the next orchid flower. The flower therefore becomes part of the wasp's, and the wasp becomes part of the flower's reproductive processes. The relations between the wasp and the orchid produce an assemblage, in 'the becoming-wasp of the orchid and the becoming-orchid of the wasp' (p.9). The wasp or the flower by itself could be considered as an assemblage of heterogeneous parts which are contingent for their functioning together as a whole, and the interactions of physiological, biochemical and affective processes with other bodies and environments produce the flows and becomings that characterise assemblages. Deleuze thinks of human bodies themselves as assemblages, asserting that:

We know nothing of a body until we know what it can do, in other words, what its affects are; how they can or cannot enter into composition with other affects, with the affects of another body (Deleuze, 1980, p.257)

Within Deleuze and Guattari's process ontology, the body is defined not by what it is, but by external relations with the bodies and forces with which it connects, 'the flows of relations through which it passes and is produced' (1987, p.287). Their philosophy rejects notions of a stable, essential, bounded self, facilitating an understanding of human experience and subjectivity as emergent from relational processes.

Assemblages have material and expressive dimensions (Malins, 2004). Deleuze asserted the heterogeneity of assemblages, and in line with Spinoza's monism and immanence, does not distinguish between discourse and objects, stating that, 'In assemblages you find states of things, bodies, various combinations of bodies, hodgepodes; but you also find utterances, modes of expression, and whole regimes of signs. The relations between the two are pretty complex' (Deleuze, 2006, p. 177). Intimate relationships have material components, such as wedding rings, cohabitation, sex, shared food and spaces, for example. In terms of its expressive

components we could identify the social, legal and emotional ties that marriage incorporates, monogamy, commitment, and laws relating to property. Assemblages of health may include treatments, diagnoses, private and public health industries, from instrument makers, pharmaceutical companies, research, as well as everyday material objects, food, medicine, and running shoes. These assemblages are also temporally and spatially organised, so they belong to and vary according to their historical and geographical context. Assemblages are in a constant state of flux, stabilization and change.

A sense of how assemblages work and produce things is encapsulated in the concept of machinic assemblages (Deleuze & Guattari, 1987). Machinic assemblages of health, for example, consist of ‘dominant discourses and discursive practices which can then envelop and stratify certain people’ (Smith, 2012, p. 84), producing particular health subjectivities. So assemblages can work as a concept to ‘map the social-cultural-material connections through which bodies...are experienced’ (Renold & Ringrose, 2011, p.392). Deleuze and Guattari’s (1987) process ontology conceptualises movement and dynamism that is so challenging for theories based on stable essentialism to model, as an inherent quality rather than as phenomena that require explanation. Assemblages can be mapped on a macro or a micro level (De Landa, 2012), and are open to inquiry in a way that conceptualisations of constructs as seamless, with internal relations, coherence or logic may not be, although the ‘relations of exteriority’ mean that, ‘the properties of the component parts can never explain the relations which constitute a whole’ (De Landa, 2012, p.195). The implications are that objects of study cannot be examined in isolation, but must be explored in their relations, contexts, and processes of becoming – relations, events and affects rather than stable subjects, identities, experiences, and worlds (Duff, 2014).

Health, as Duff (2014) and Fox (2005) argue, is more clearly conceived as a set of relations between diverse bodies, such as patients and their medication. Adherence to medication, for example, is traditionally understood as a risk-reduction strategy. Non-adherence appears irrational, and from a neoliberal viewpoint, irresponsible (Rosenbaum, 2015). But within the assemblage that is medication, there are lines of flight from both of these positions. For example, people may resist

the way that cholesterol-lowering medication constructs them as ill and/or as someone who lacks the willpower to reduce their cholesterol through diet and exercise. Non-adherence can also be understood as a form of risk management in cases of feared or actual side effects in a deterritorialisation of discourses of risk reduction. In Deleuzian terms, causality is understood not as a linear exchange, but as affective; bodies' capacities to act and be acted upon in a dynamic rhizomatic process. Dualistic, causal relationships are replaced by multiplicity, relations, and assemblages. Assemblages, with their emphasis on 'emergence, heterogeneity, instability and flux' (Duff, 2014, p.33) stand in opposition to enduring, stable social structures. Duff (2014) argues that this perspective offers a new way of considering determinants of health by examining the 'effects they generate (and the concrete relations they establish) between diverse bodies' (p.35). Deleuze conceptualises desire as the affirmative, productive force behind these 'restless, morphogenic processes' (Duff, 2014, p.14), as I discuss below.

Desire.

Deleuze's notion of desire is based on what Spinoza termed 'conatus', a fundamental will or striving to persist in being (Deleuze, 1988). For Deleuze, desire is not connected to pleasure, nor is it driven by lack, but is a primary productive force, 'the productive energy flow that moves between bodies in assemblages and enables them momentarily to alter their modes of composition' (Malins, 2004, p.85). Desire is not used in its common sense of wanting what we do not have, but rather an affirmative tendency or attraction towards things which increase our powers of being and acting. Desire can flow freely or be constrained in what Deleuze and Guattari (1987) called 'smooth' and 'striated spaces' (p.474). Repressive systems of power and knowledge, social structures and rules organise or striate social spaces and constrain desire. Deleuze and Guattari use the terms molar and molecular to designate, not differences in scale, but differences in movement. Molar powers are characterised by their relative stability; they are the calcified, normative structures that organise society, such as understandings of gender, race, religion, and class. Molecular movement, on the other hand, refers to the affective process and deterritorialisations that can eventually destabilise molar structures.

Deleuze and Guattari conceptualise these molecular movements as resistance to fascisms that limit and oppress. Desire functions as ‘positive lines of flight, because these lines open up desire, desire’s machines, and the organisation of a social field...Desire never resists oppression, however local and tiny the resistance, without the challenge being communicated to the capitalist system as a whole’ (Deleuze, 1990, p.19). Molar powers may appear stable, but as grains of sand move in a sand dune, the broad topography eventually shifts because of molecular movements and flows. Deleuze echoes Foucault’s conceptualisation of power, change, and resistance, ‘power is not localised in the state apparatus, and nothing in society will change if the mechanisms of power that function outside, below and alongside the state apparatuses, on a much more minute and everyday level, are not also changed (Foucault 1975, p.1626-7). Deleuze and Guattari (1987) consider objects, bodies, and institutions as ‘desiring machines’ that continually produce new relations and connections, and focus on how ‘desire flows through and between (human and non-human) machines/assemblages/bodies in complex ways’ (Ringrose, 2011, p.599). The power of desire to produce change is accounted for by Deleuze’s theory of affect, as I discuss below.

Affect.

In contrast to contemporary understanding of affect as a synonym for emotion, Deleuze adopted Spinoza’s differentiation between the two. According to Spinoza, emotions are the body’s registering and consciousness of affective, relational processes. Affects which increase capacities to form relations are registered as positive or joyful emotions, and those that diminish them as negative (Deleuze, 1988). These affects can take place on a micro, physiological level, or a macro, social level, accounting for the impact of diverse social, environmental and material encounters on human health. Affect is the product of ongoing dynamic connections and relations between bodies and objects, both human and non-human, that bring about changes in the affected body. There is no separation of body and context - the body is produced moment by moment by ‘given relations of movement and rest, speed and slowness...the sum total of the affects it is capable of at a given power or degree of potential’ (Deleuze & Guattari, 1987, p.287). Affect is transitory, and precedes perception or consciousness of the encounter, ‘that

indescribably moment before the registration of the audible, visual, and tactile transformations produced in reaction to a certain situation, event, or thing' (Colman, 2010, p.11).

Affect offers a way of understanding existence as a process of becoming rather than a state of being, since affects are relational and processual, 'the unfolding of personal powers to act and understand within a complex web of forces made up by a world of finite beings and things *affecting* one another' (Brown & Stenner, 2001, p.97). Like many of Deleuze's concepts, becoming is embedded in and not easily extracted from other interconnected elements of his philosophy. But in relation to affect, becoming can be understood, not as a stage in a series of events, but rather as the process of change itself that continually produces the new and the self as 'a constantly changing assemblage of forces, an epiphenomenon arising from chance confluences of language, organisms, societies, expectations, laws' (Stagoll, 2010, p.27). In this way, Deleuze's theory of affect overcomes the separation of the personal and the social and accounts for how external social forces act upon the individual (Massumi, 2001). Deleuze's notion of becoming captures these processes of subjectivity that have no stable present or final form. It is an openness to change, to the formation of new relations, as desire exceeds the boundaries of molar organisation. Rather than stable, bounded entities acting upon each other in ways that need to be accounted for, Deleuze conceptualises subjectivity as constituted by relations of exteriority (Deleuze, 1990), produced in the interactions between bodies, discourses and objects. The duality of outside and inside, external and internal is overcome, allowing 'fluid, relational understandings of the ways that social relations become folded into patterns that come to be seen as individual bodies' (Tucker, 2006, p.514). Using the example of how diagnostic categories, such as schizophrenia, produce subjectivities, Tucker (2006) explores how mental health service users 're-code their experience in relation to these categories and find ways of 'living them out' in their own lives...Experience is then infolded so that the outside (culturally derived categories) becomes inside (lived experience)' (p. 214). Affect is this event, or 'infolding' that takes place in the event of interactions between different bodies.

Massumi (2003) draws attention to the relational nature of existence, and argues that affect means that:

we are never alone. That's because affects in Spinoza's definition are basically ways of connecting, to others and to other situations. They are our angle of participation in processes larger than ourselves. With intensified affect comes a stronger sense of embeddedness in a larger field of life — a heightened sense of belonging, with other people and to other places (p.115).

In Deleuzian terms, causality is understood not as a linear exchange, but as affective, bodies' capacities to act and be acted upon in dynamic, rhizomatic process. Dualistic, causal relationships are replaced by multiplicity, relations, and assemblages.

Relations of power are a component of assemblages, that striate or cut through spaces of intimate relationships or health, for example. Affect is 'the effectuation of power' (Deleuze & Guattari, 1987, p.284), and so affective flows and shifts 'thus presents a way of analysing power relations within and between bodies and assemblages, and mapping 'flows of energy' and desire' (Ringrose, 2011, p. 602). Assemblages can be life-affirming, increasing capacities to act and be in the world, or life-destroying, limiting and shutting down of creative desire, and the power to connect. Deleuze and Guattari (1987) argue that an assemblage is not defined by its components, but precisely by the lines of flight and deterritorialisations, however transitory, by which it is cut through. Lines of flight, along which marginalised or uncaptured bodies coalesce and flee, can be productive of new becomings and affects. But lines of flight can also be destructive, and Deleuze used the example of drug use that can offer escape, but also reduce capacities and powers. In contrast to binary categorisations of relationships and interactions as positive or negative, however, Deleuze offers Spinoza's statement that the huge number of possible relations between bodies means that 'the same object can agree with us in one respect and disagree with us in another' (1970, p.33), accounting for multiplicity, parallelisms, and the coexistence of contradictions and conflicts, which defy simple resolution.

Ethics.

Both Foucault and Deleuze rejected morality as the imposition of transcendent rules based on a pre-existing order. Foucault argued that moral rules are

not universal, but rather socio-historically contingent, subjectifying discourses. Deleuze's theory of ethics provides a framework for navigating complex phenomena such as health, attending to affirmative as well as negative aspects and ramifications of each (Duff, 2014). Deleuze drew on Spinoza's notion of ethics not as stable constructs, but as affective, fluid, and relational. Affect relates to the body's capacity to act and be acted upon, and so forms the basis of an ethics in which positive or affirmative phenomena are those that increase capacities to relate and act, while negative ones reduce them. Affects are evaluated as good or bad according to the changes and transformations that occur in the affected body or object (Deleuze, 1988; Massumi, 2001). Deleuze and Guattari (1987) thus reject the notion of universal moral rules in favour of an ethics which is local, embodied, and personal. Objects and happenings are not judged on the basis of an essential nature, but can only be evaluated in relation to how they affect other bodies' capacities and powers.

Applied to issues relating to health, Deleuze and Guattari (1987) offer us a way of rethinking the impasses and contradictions inherent in neoliberal understandings of personal and civic responsibility for lifestyle behaviour and health. They reframe questions of essential nature to ask their functionalist questions about how something works and for whom. Rather than thinking about phenomena such as weight, diet, or exercise as intrinsically or morally good or bad, Deleuze advocates investigating the ramifications and the highly individual and ambivalent ways that people are affected (Deleuze, 1980; Duff, 2014). Exercise may be experienced affirmatively by increasing a patient's connectedness and capacities in their recovery from CHD, but it may also diminish or disempower through fear of a recurrence of chest pain, a dislike of physical discomfort, or through feeling judged, out of place, or embarrassed in an exercise class. When asking what affects a phenomenon affords, we can acknowledge the complex conditions of possibility that produce health, and withhold the generalisations and judgements that arise from simplistic paradigms of rational lifestyle choices.

Time.

The final concept that has relevance for how couples manage lifestyle change is Deleuze's theory of time, for which he drew on the philosophy of Henri Bergson.

From these complex theories, I isolate notions of time as non-linear and subjective in order to conceptualise participants' experiences of illness, recovery, aging and health as multiple and parallel. Time is traditionally understood as a universal force with a linear trajectory, within which events and lives occur, and by which they are measured. But Bergson (2007) challenged understandings of time as a prior or external force, and instead conceptualised time as the unfolding of subjective experience, arguing that traditional concept of time is only a measure of life and change, not life itself:

usually when we speak of time we think of the measurement of duration, and not of duration itself. But this duration which science eliminates, and which is so difficult to conceive and express, is what one feels and lives (Bergson, 2007, p.11)

Bergson's theory of duration rejected linearity and the separation of the past, present and future into discrete, successive segments, which he termed the spacialisation of time. Bergson's theory of time therefore fits within a process ontology, as he defined duration as 'unceasing creation, the uninterrupted up-surge of novelty' (1946, 2007, p.16). The unpredictability and novelty of unfolding experience is connected to Bergson's conceptualisation of the virtual and the actual.

Traditional understandings of the possible and the real are based on the assumptions that the real is more real than the possible, and that the possible holds greater potential than the real. When something happens, it is the enactment of something that was already mapped out as a possibility, so there is a determinism to reality. Also, reality involves a narrowing down of possibilities in the becoming real of a finite number of possible happenings (Deleuze, 1991). In Bergson's theory of time, the virtual and the actual are equally real. What is possible, imagined or past is no less real than actualised objects or events (Bergson, 2007). Deleuze and Guattari's notion of becoming encapsulates the process of the actualisation of the virtual, but rather than a closing down of possibilities, becoming produces new virtualities, increasing the potential for further actualisations. Deleuze and Bergson's theory affords a rich conceptualisation of time that includes the virtual and the actual not as

mutually exclusive or as more or less real, and of events or happenings that open up rather than close down possibilities.

In addition to this theorisation of novelty and possibility, Bergson and Deleuze proposed that the past and the present do not denote two linear, successive moments, but two elements which coexist: ‘One is the present, which does not cease to pass, and the other is the past, which does not cease to be but through which all presents pass’ (Deleuze 1991, p.59). Deleuze accounts for the co-existence and accessibility of past and future when he writes that ‘there is no present that is not haunted by a past and a future, by a past that is not reducible to a former present, by a future that does not consist of a present to come’ (2005, p.36). Deleuze’s concept of time affords a recognition of co-existing and distinct realities of disease as ‘different versions, different performances, different realities that co-exist in the present’ (Mol, 1999, p.79). Recognition of multiple time frames opens up possibilities for thinking about the complexities of time as it is experienced, and provides a theoretical framework for the ways that couples talk about time in relation to lifestyle change, recovery, and death.

Health promotion often refers to mortality (BHS, 2016), and experience of serious illness inevitably increases awareness of death, but there is a lack of affirmative discourses and practices relating to death, to the extent that Willig (2011) argues that patient who accepts or ‘who wishes to engage with their mortality will struggle to find a social space within which to do so’ (p.16). For Deleuze, however, the co-existence of the virtual and the actual and the ceaseless processes of difference and change that constitute life means that death ‘is coextensive with life...living is inseparable from the partial deaths that it goes through’ (Colombat, 1996, p.241). Death is not the end of subjectivity nor the antithesis of life, since even when we die, ‘one is nonetheless affirmed as an individual’ (p. 242), and in life, because it is always ahead of us, it is ‘a virtual that never gets accomplished – we are always in the process of but never complete dying...essential to the creation and proliferation of life and thought’ (Colombat, 1996, p.242). The sense in which death is always present and is never achieved thus breaks down the dichotomy between life and death, and in so doing, opens up possibilities of an affirmative, more accepting view of death.

Elizabeth Grosz (2000) explores the value Deleuze and Bergson's philosophies in conceptualising the future in affirmative ways. Current neoliberal health discourses stop short at the moment that health is achieved through responsible consumption and appropriate care of the self. No clear future or picture of their inevitable end is offered for people who reach this ideal and optimised state of being, but such discourses have problematized ill-health, and used it in a 'pedagogy of danger' that evokes fear of aging and death (Crawford, 2006, p.508). Instead, Grosz proposes that the philosophical tradition upon which Deleuze draws is pragmatic and non-deterministic, producing the inspiration and the means to bring about effective action in the world, through a recognition of ever-proliferating possibilities: 'This is what time is if it is anything at all: not simply a mechanical repetition, the causal effects of objects on objects, but the indeterminate, the unfolding and the emergence of the new' (Grosz, 2000 p.230).

Health.

Deleuze's conceptualisation of material, embodied and affective processes have been applied to the study of both mental and physical health (e.g. Brown & Stenner, 2001; Fox & Ward, 2006). Wood, Ferlie, and Fitzgerald (1998) highlight the limitations of traditional positivist and purely constructionist approaches in capturing these interactions. They argue that health and illness are constrained and made possible by social, cultural, and physiological factors, and that such possibilities and constraints produce identities within assemblages of health relating to sport, appearance, ageing, or lifestyle disease, for example. Deleuze's philosophy can thus be used to conceptualise health as complex, multiple, dynamic and unpredictable rather than a stable state which can be achieved and maintained through simple, rational lifestyle decisions and choices (Duff, 2014).

Understanding health as an assemblage of material and non-material objects and forces, and the affective flows between those components provides tools to map the dynamic and affirmative processes involved in individuals' adoption, disruption, and transformations of dominant health discourses. Assemblage analysis does not privilege discourse or meaning over other dimensions and components, material and non-material (all are equally 'real' for Deleuze), of an assemblage, but focuses on

the ‘processes of assembly...By refusing to think in totalities and essences, it offers a theoretical framework for understanding how networks of people, genes and technologies are assembled in novel ways’ (Arribas-Ayllon, 2016, p.135).

Intimate relationships.

Applying Deleuze’s ideas to the second strand in this study generates new and affirmative ways of conceptualising love and intimate relationships, and of understanding their affinity with health. For Deleuze, love is not a stable, inner state, but a set of relations or connections with a human or non-human other that registers as a positive emotion, not in the sense of a value judgement of the emotion, but in terms of its increase or decrease in one’s capacities and powers to act in the world. Deleuze and Guattari would ask not what love is but rather what it does, how it works and for whom. Deleuze and Spinoza conceptualised love as an affect, an increase in the power to act that is connected with a particular object or person (Deleuze, 1988). Since thought and physical experience are, for Deleuze and Spinoza, different aspects of the same mode, the physiological and neurobiological experiences of love exist in parallel to these affects. Their concept encompasses love for human and non-human others, material and immaterial-music, place, animals and nature, but the common factor is that such love increases capacity to be and act in the world.

In Deleuzian terms, love is a desiring machine, producing subjectivities and embodied experiences: ‘different types of multiplicities that coexist, interpenetrate, and change places – machines, cogs, motors, and elements that are set in motion at a given moment, forming an assemblage productive of statements “I love you” (or whatever)’ (Deleuze & Guattari, 1987, p.36). This productive, performative love is affirmative according to Spinozan and Deleuzian ethics, not according to a universal moral code, but because it frees up desire and possibilities for creating new connections and capacities. Because for Deleuze and Guattari (1987) love is a form of desire that opens up new flows and connections, they are critical of what they term Oedipal love – the ways in which love has been overcoded, territorialised, and calcified by sociocultural forces. Marriage can be understood as a molar, organising institution which can, however, be deterritorialised by affective connections between

people, and they offer a concept of love as a molecular, unique assemblage. To love somebody:

is always to seize that person in a mass, extract him or her...then to find that person's packs, the multiplicities he or she encloses within himself or herself which may be an entirely different nature...To join them to mine, to make them penetrate mine, and for me to penetrate the other person's. Heavenly nuptials, multiplicities of multiplicities (Deleuze & Guattari, 1987, p.35).

Within Deleuze and Guattari's affective process ontology, love is 'exactly this creative novelty of connection, this joining of multiplicities' (Protevi, 2007, p.188) that produces new affects and subjectivities. Optimally, a body is free to make these connections, freed from the organisation of the organism that pins it down and defines it according to its biological and/or social functions. This requires a recognition of the 'body as a multiplicity, respecting the uniqueness of its assemblage...All love then must be a...reshuffling of the stereotyped patterns and triggers of Oedipal living' (Deleuze & Guattari, 1987, p.134). For Deleuze and Guattari, the imposition of gendered norms is part of the organising processes that striate, limit and govern intimate relationships, which Foucault suggests love can subvert. Protevi (2007) identifies love as a 'mutual experimental deterritorialisation ...Love is complexity producing novelty, the very process of life' (p.191).

Deleuze and Guattari identified 'the great molar powers of family (oedipalization), career (capitalism), and conjugality (heterosexual marriage)' (1987, p.257), but this does not mean that these phenomena are fixed in their blocking of desire. The non-interiority, instability, and performativity of love is reinforced by Deleuze's statement that '[N]on-oedipal love is pretty hard work', a matter of 'experimenting on yourself, by opening yourself up to love and desire' (Deleuze, 1995, p.10). He echoed Foucault's evocation of the creative power of love. Deleuze argued that that love is not a stable preserve of any groups, but is a productive force, 'the transversal relations that ensure that any effects produced in some particular way (through homosexuality, drugs, and so on) can always be produced by other means. We have to encounter people who think 'I'm this, I'm that' and who do so, moreover in psychoanalytic terms (relating everything to their childhood or fate), by thinking

in strange, fluid, unusual terms: I don't know who I am – I'd have to investigate and experiment' (p.11). His concept of love echoes Foucault's recognition of love as something that is has been institutionalised and normalised, but which still has creative and subversive potential.

In this sense, love and health are linked, not because their connection is determined by biological or social imperatives, but because they are both defined by their potential to increase powers and capacities through affective connections and relations. Assemblages of love and health produce flows of desire, and for people in long-term relationships, these assemblages are interconnected, producing an even greater number of possibilities. Assemblages are over-coded by social and political institutions which create lines, striations, which can block and limit as well as set free. Marriage for example, is a heavily coded space, which can increase capacity through love, and norms of care, but which can constrain and exclude other affects and practices. The wide variety of relations that characterise love, its spatial, relational and political dimensions, and ethics can be explored by asking, with Deleuze and Guattari, not what love is but rather what it does, how it works, and for whom.

In summary, Deleuze reframed questions that engage social and human sciences. He and Guattari were functionalists who conceptualised performativity, practice, and affect (Butler, 1997; Clough, 2007), and their process ontology offers a theoretical framework for thinking about the complexity and dynamisms of human experience, taking into account emotions, embodied experience and materiality, as well as discourse. In the following sections, I examine the ways in which Foucault and Deleuze and Guattari's concepts overlap, but also the differences which allow their ideas can be used together to provide a fuller conceptualisation of experiences of coupledness, illness, and health.

4.3 Thinking with Foucault and Deleuze: Implications for Method.

Foucault and Deleuze were contemporaries whose theories overlapped in important ways, as Deleuze affirmed, 'our method's not the same, but we seem to meet him on all sorts of points that seem basic' (2006, p.22). The previous sections laid out elements of the poststructuralist philosophies of Foucault, Deleuze and

Guattari that can be used to conceptualise health and intimate relationships in response to gaps in the literature identified in chapter 3. These gaps relate particularly to the dynamism and unpredictability of couple health interactions and the potential for negative as well as affirmative ramifications of lifestyle change as couples negotiate wider discourses of health and healthy lifestyle. Gottman and Notarius (2000) drew attention to a lack of literature examining power within intimate relationships. Although critical approaches have been applied to health and to intimate relationships, there is a lack critical literature that includes couples and their management of lifestyle diseases and the ways that couples adopt, resist or transform wider social discourses of lifestyle and lifestyle change in the presence and absence of illness. In the following sections, I will explore how Foucault and Deleuze's concepts can be applied to illuminate these gaps in complementary ways.

Power and desire.

Bogue (2000) draws attention to the similarity of Foucault and Deleuze's concepts of power, arguing that 'power for Foucault, like desire for Deleuze and Guattari, permeates all social relations and penetrates the body' (p.73). All were concerned not with the 'what' of power and desire, but the 'how' of its workings, and the ways in which is productive of new subjectivities, possibilities, and ways of being. However, Foucault saw power as a primary force, and he developed his theory of power more fully than Deleuze. Power is not confined to domination, and it is in 'the play of power relations and resistances' that 'human beings constitute a relation to themselves...a complex and fragile thing' (Foucault, 1989, p.789). According to Foucault, it is productive of plural, multiple, selves that are open to desubjectification and transformation. People experience themselves and are experienced by others as a unity, but despite this apparent stability, identity is always multiple, unfixed, and contingent. Foucault's concepts of technologies of power and technologies of the self, whereby people are brought to work on themselves have clear applications to contemporary understandings of health as achievable through following healthy-lifestyle advice, and how wider discourses shape couples' understandings and practices of health through processes of normalisation, surveillance, and hierarchical judgement.

For Deleuze (1994), however, it is desire that is the primary productive force, and he considered power to be subordinate to desire: ‘collective *agencements* (assemblages) would have many dimensions, and *dispositifs* of power would only be one of those dimensions’ (Deleuze, 1997, p.187). So power can be thought of as a dynamic element in assemblages of both health and intimate relationships, while maintaining Foucault’s understanding of power as sets of relations that flow on macro and micro levels. Deleuze concurs with Foucault’s notion of governmentality, and his analysis of the ways in which families, schools, and hospitals bring individuals under diffuse and continuous control. But Deleuze defines normativity differently. Rather than an always-oppressive force, he construes it as the fullest capacity to connect and act. Health is normative not in the sense that it is an external ideal towards which people should aspire, but as optimal in that it provides the maximum potential for possibility and connectedness, the promotion of ‘creativity necessary to produce novelty. Normativity, as such, provides the measure of life extended to its limits, at the reach of “its power of acting”’ (Deleuze, 1992, p.256). Deleuze’s concepts of desire and affect encapsulate Foucault’s recognition of power as a creative force, and provide a means to evaluate forms of governmentality, such as health promotion, in terms of whether they increase or diminish possibilities and creativity. Deleuze and Guattari’s notion of deterritorialisation maps onto Foucault’s concepts of resistance, but their primary, affirmative concept of desire accounts for the unpredictability, novelty, and creativity of the ways in which couples not only resist, but transform health discourses and practices. Health and intimate relationships can each be considered as a ‘site of intense power relations at play, but also as a plane for the production of intense flows of desire, and can create moments for thinking differently about our actuality...imagining possibilities of following lines of flight, becoming other’ (Tamboukou, 2003, p.220). The intersection of power and affect points to the value of thinking with both Foucault and Deleuze in the mapping of the complexities of couples’ health interactions.

Foucault proposed that critical thinking can uncover the contingencies of power and normativity, in order to think differently, and to react differently to power relations and the construction of truth and knowledge. Deleuze conceptualises this perspective affirmatively, identifying it as a ‘third axis’ which co-exists with power

and knowledge. referred to the impasses and constrictions that disciplinary power creates, 'where power itself places us, in both our lives and our thoughts as we run up against it in our smallest truths' (Deleuze, 2006, p.79), and he proposed an affirmative line of flight from this shutting down of creativity and desire, a reterritorialisation that, 'would be like a new axis, different from the axis of both knowledge and power. Could this axis be the place where a sense of serenity would be finally attained and life truly affirmed?' (p.79-80). Deleuze suggests some freedom is found in relations not with power or knowledge but with oneself, 'from which the subject in different ways, hopes for immortality, eternity, salvation, freedom or death or detachment' (p.80). I thought about this concept in the context of the ways that neoliberal health messages can block and restrict people's subjectivities and practices within paradoxical and negative cycles of anxiety and control (Crawford, 2006). Foucault stated that normalising forces could be actively resisted, though activism arises not from optimism, but from fear and pessimism:

My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper- and pessimistic activism (1984, p.343)

Deleuze's notion of deterritorialisation and resistance was more affirmative, and he located resistance in the escape from organising forces and the creation of new, embodied, and affective experiences and ways of being, speculating that, 'modern subjectivity rediscovers the body and its pleasures...The struggle for subjectivity presents itself therefore as the right to difference, variation, and metamorphosis' (Deleuze, 2006, p.86). The possibility of serenity and acceptance has implications for understanding the ways that people can release themselves from dominant health discourses, and acknowledge and accept difference, and even death (Willig, 2011).

Health practices within intimate relationships are sites where, 'economies of power and economies of desire produce realities, but also incite deterritorializations and allow lines of flight, irrespective of the fact that they will also allow grounds for reterritorializations to occur' (Tamboukou, 2003, p.18). Power and desire do not

have be polarised or melded, as from a methodological point of view, both concepts provide lenses that afford different ‘cuts’ in the data (e.g. looking at power or desire), but which can be transposed together, like features on transparent sheets that build up layers of details of a map and allowing material, embodied, and affective dimensions of experience to be explored.

Discourse.

Foucault and Deleuze shared a conceptualisation of language as active and productive. Deleuze adopted Foucault’s theories of language and discourse, and acknowledged that, ‘discursive formations are real practices...and tend to promote and even express mutation’ (Deleuze, 1988, p.13). Hook (2001) enumerates the principles which guide Foucault’s methodology, and which demonstrate connections with Deleuze’s metaphysics. Firstly, Foucault characterises discourse as an event rather than a creation, and asserted that discourse analysis should therefore be concerned with ‘rediscovering the connections, encounters, supports, blockages, play of forces, strategies’ (Foucault, 1981, p.6). Although Deleuze proposed that language and discourse are elements in assemblages, Foucault’s conceptualisation of language matched the way that Deleuze considered language to work. Deleuze does not distinguish between emotion and reason, knowledge and experience, arguing that knowledge is always experiential and affective, and, ‘grasped in a range of affective tones: wonder, love, hatred, and suffering (1994, p.139). Foucault’s much fuller theorisation of knowledge, language and discourse, and the analytic methods based on his ideas offer a framework for examining the interplay between wider health discourses, and the ways in which those discourses are adopted and resisted in couple health interactions. Deleuze and Guattari’s concept of assemblages affords an exploration of how discourse works with other embodied, material, and non-material dimensions of assemblages of health and intimate relationships.

Gender.

Both Deleuze and Foucault shared a concept of gender as produced by subjectifying forces. Gender powerfully over-codes, or striates, social spaces, and despite Foucault’s view of sex as a cultural norm rather than a biologically determined category, he affirms that these norms are materialised in bodies, though it

is always an incomplete and unstable conformity. According to Foucault's ideas of 'regulatory ideals', gender as a category 'is part of a regulatory practice that produces the product it governs...this materialisation takes place through certain highly regulated practices' (Butler, 1993, p.1). These practices and discourses produce and reproduce gender through reiteration of norms. As with other normalising processes, gender norms work through exclusion, creating abject or unviable subjects whose practices, bodies, and identity do not fit within recognised or accepted categories.

For Deleuze and Guattari (1987), gender is a molar, binary force, but their notion of the molecular also allowed them to conceptualise greater fluidity in the individual relations between people, bodies and objects which produce gender as multiple rather than binary, a 'multiplicity of molecular combinations bringing into play not only the man in the woman and the woman in the man, but the relation of each to the animal, the plant etc.: a thousand tiny sexes' (p213). Gender is thus produced in the relations between different bodies and forces, accounting for multiplicity, the incomplete capture of the body and subjectivity by gender norms, and opening up creativity and flows, which for Deleuze and Guattari meant affirmative possibilities. Mainstream and critical literature have focused on gender in relation to health and couples' health interactions, and both Foucault, Butler, and Deleuze and Guattari's concepts offer lenses through which gender and how it is constructed through relationship and health practices may be understood.

Assemblages and complexity.

Deleuze and Guattari's concept of assemblages is also compatible with Foucault's theory of power, and both can be combined to account for affirmative as well as negative outcomes in the exercise of disciplinary power through health discourses, as '[a]ssemblage thinking reveals an affirmative biopolitics that emphasises the productivity of relations between genetic knowledge and subjectivity, though not at the expense of understanding a biopolitics of control' (Arribas Ayllon, 2016, p.137). Annemarie Mol (1999) considers the implications of Foucault's assertion that the performativity and situatedness of reality depends on multiplicity, 'if reality is done, if it is historically, culturally and historically located, then it is

also multiple' (p.75). Thinking of health and relationships as assemblages can provide a framework for exploring the dynamic, intersecting material and non-material multiplicities that constitute both. Mapping assemblages of health and intimate relationships allow us to account for the fluid dynamics that qualitative and critical studies suggest is present in couples' health talk and behaviour about health (MacLean et al., 2015; Seymour-Smith & Wetherell, 2006).

Foucault, Deleuze, and Guattari's ideas lead us to expect that intimate relationships and health behaviour will be shaped by sociocultural as well as material forces without being determined or defined by them. Analyses based on their philosophy and ethics could therefore reduce the potential for reductionist categorisations and stigmatisation of couples' health behaviour. Deleuze and Foucault's ideas overlap in important ways, producing analytic methods that are complementary, but their differences illuminate diverse aspects of health and intimate relationships – togetherness, risk, and time- to provide a rich theoretical framework for the complex, varied, and often affirmative ways in which couples jointly manage health and healthy living.

In the following chapter, I discuss the method of the studies that is based on the ontologies of Foucault, Deleuze, and Guattari. The method and analytic strategy were developed in order to apply concepts relating to power, knowledge, discourse, and risk that the literature suggests are relevant to couples' experiences of managing each other's health, while Deleuze and Guattari's theories of affect and Deleuze's notions of time produced understandings of health and intimate relationships that provided a framework for an open and ethical exploration of couples, health and relationships. I present the method of each study in turn, before discussing in more depth the analytic strategy and reflexive processes that guided the analysis, and which were common to both studies.

Chapter 5 Method

Introduction.

In the previous chapter, I described the theoretical framework and the methodological theory that builds upon its epistemology and ontology. I outlined how the philosophies of Foucault, Deleuze and Guattari form the basis for qualitative methods that can be used together to examine the complexities of health practices in the context of intimate relationships. The scope of their theories encompasses the complexities of interpersonal health practices, and informed my choice of method and analytic strategies for Study 1 and 2. I chose qualitative interviews as a way to elicit accounts of couples interactions and practices related to health and healthy lifestyle (Kvale & Brinkmann, 2009). Since my focus is upon how couples take up wider discourses of health and healthy living in their day to day lives, in order to draw on Foucault's concepts of power, knowledge and governmentality, and the production of subjects through processes of surveillance, normalisation, and hierarchical judgement (Foucault, 1988), I used a dual-focus Foucauldian discourse analysis (FDA) to examine how couples negotiate and position themselves in relation to expert knowledge and norms of health and relationships (Fairclough, 2001; Willig, 2000, 2008). In addition to the FDA, I used an analytic strategy based on concepts developed by Deleuze and Guattari to map the affective, embodied, transformative, temporal, and affirmative dimensions of participants' accounts.

In this chapter, I describe the method used in the two studies in this thesis, which is based on the epistemology and ontology described in the theoretical framework. To explore the ways in which broad social discourses of health are adopted, resisted, and jointly negotiated by people in long-term relationships as they manage healthy living and lifestyle change, I conducted two studies. The first was a smaller, exploratory, qualitative interview study with seven opportunistically-sampled people in long-term relationships, which elicited talk about their management of health and healthy lifestyle within long-term relationships. In the second larger, longitudinal study, I interviewed 22 participants (nine couples and

four men in long-term relationships who chose to be interviewed alone), in couples where one partner had been newly diagnosed with CHD.

I begin by presenting the background, design, sampling and recruitment of participants, ethical considerations, and procedure of each of the two studies in turn, followed by method sections that applied to both studies, including the quality criteria that were applied to both studies, and the method of data analysis that was used in both Study 1 and Study 2. Throughout the research, I engaged in reflexivity which contributed to the development of the study design, ethics, theoretical framework, and analysis at different stages, so I will include reflexive commentaries where they apply.

5.1 Study 1.

The original focus of this study was a broader exploration of couples' experiences related to embodiment, and how they negotiate dominant understandings of body image, health, body size, fitness, exercise and eating within their intimate relationships. The dominance of talk about health and healthy lifestyle over concerns with appearance in these exploratory interviews led me to narrow the focus of the research to examine the complex ways that couples talked about the topic of lifestyle. Intimate relationships are often a site of shared health and lifestyle practices, and although the literature indicates that couples share health risks and benefits, there are gaps in the literature about the ways in which partners manage their own and each other's lifestyle. In particular, there is a lack of critical literature relating to couples' negotiation of dominant and pervasive healthy lifestyle advice and information, and the ways in which these wider discourses may be taken up or resisted in couple health interactions. Related to the issue of dominant discourses, there is the potential for health psychology research in the area of intimate relationships and lifestyle to perpetuate dominant social and scientific discourses and stereotypes in ways that imply judgement and culpability (Kirk et al., 2014). Finally, mainstream biomedical and health psychology research indicates the complexity and dynamism of couples' health practices, but does not draw all of these elements together into a theoretical framework that accounts for the variability of behaviours and outcomes. Idler, Boulifard and Contrada (2012) identify a need for qualitative

research that examines the micro-processes involved in couples' day to day health interactions, while critical approaches consider how scientific and social discourses can problematise people and behaviours, and explore power relations, such as those involved in partners' attempts to influence or control each other's behaviour (Gottman & Notarius, 2000). The gaps in the literature seemed significant enough to warrant an exploratory qualitative study which takes a critical, poststructuralist approach to examine how people in long-term relationships talk about health, embodiment, and their lifestyle practices.

Design.

The design of Study 1 was a relatively unstructured qualitative interview study, conducted with seven participants and using a word-elicitation design which produced accounts of issues relating to bodies, health, and healthy lifestyle in long-term relationships. I used a dual-focus Foucauldian discourse analysis to examine partners' talk in the context of powerful social discourses of health and healthy lifestyle, and to explore the ways in which health information is adopted and resisted. Participants' occasional transformation of dominant understandings of healthy living in unexpected ways led me subsequently to analyse the data using Deleuze and Guattari's (1987) concepts of affect and assemblages.

Participants.

An opportunistic sample of participants was recruited through advertisements at the university and within the local community. The posters invited participation from men and women, who had been in a relationship for at least three years, and who were willing to talk about body image. No sexual orientation was specified for the study, though all the respondents identified as heterosexual. Potential participants who were interested and willing to take part emailed me. The rationale for the minimum relationship length was to ensure that the partners had experience of living and managing their lifestyle together, while avoiding the very early stages of a relationship, when either couples might still be in a period of adjustment to each other, which Marazziti, Akiskal, Rossi, and Cassano (1999) suggest lasts from 12 – 18 months. Five women and two men between the ages of 21 and 49 with relationships ranging from 3 to 24 years were recruited from advertisements in the

university and in the local community. Their occupations included manual, administrative, public service jobs, and postgraduate study, the sample included full-time and part-time workers, and all participants had at least some post-secondary level education. See Figure 1 below for a summary of their ages, employment and relationship length.

Table 1. *Study 1: Participant Demographic Information*

Name	Age	Relationship status	Relationship length	Employment status
Elena	23	Cohabiting	3 years	Postgraduate student and part-time care worker
Emma	48	Married	16 years	Administrative assistant
Hannah	32	Cohabiting	4 years	Public service worker
Joe	25	Married	6 years	Manual worker
Lewis	47	Married	24 years	Public service worker and part-time student
Liz	28	Married	7 years	Postgraduate student
Sue	35	Cohabiting	4 years	Public service worker

Interview design and materials.

Since lifestyle, health and bodies involve powerful norms, it was difficult to develop questions that did not reinforce those norms, such as asking about weight in a way that assumed it to be problematic, for example. A further problem with an interview-question schedule is that it sets the agenda for the interview, and may prioritise topics and content that may not match the interviewees' most salient experiences and concerns. Finally, asking direct questions about long-term relationships, health and lifestyle practices could also be intrusive, and undermine ethical undertakings to respect participants' boundaries. In order to resolve these difficulties, I developed a novel elicitation task using a set of cards with single words on each, from which participants could choose a topic they wanted to talk about. The words were developed by compiling a list of questions that covered the scope of the research questions on topics relating to health, weight, and appearance, and then highlighting only the key words in each question, such as 'weight' and 'relationship'. Those words were then printed onto cards. Given the pervasiveness of

body dissatisfaction among men and women (Ogden & Taylor, 2000), I ensured that the cards included affirmative words, such as 'hope', in order to capture the potential for positive dimensions of participants' talk. Combined, this process produced a list of 20 words including: love, health, weight, clothes, fat, other people, food, exercise, going out. There were also blank cards to allow participants to introduce topics they considered relevant but that were not already on the cards. (See Appendix A for a full list of words).

Procedure.

Participants were offered the option of being interviewed in a place of their choosing, or a comfortable, private interview room at the university. Six interviewees chose this option, and one was interviewed in his home. After a verbal description of the study, participants were given the information sheet to read (see Appendix A), and were given the opportunity to ask questions, and were reminded of their right to withdraw from the study at any time, and to have all or part of their interview data deleted up to the date when the analysis would be completed, and they signed consent forms (see Appendix A). At the start of the interview, the cards were laid out on the table, and when they were ready to begin the audio recorded interview, I asked if any of the words stood out for them. They were invited to talk with or without using the cards, or to add words to the blank cards as they wished. Follow-up questions were asked, and points were clarified or restated, but my goal was to listen actively, to intrude as little as possible, and to allow the interviewees to direct the talk.

The most commonly chosen words were weight, relationship, fat, healthy, criticise, acceptance, reassurance, clothes, listening, other people, but the talk in the interviews ranged across the topic areas, even if the related word cards were not chosen. Topics were talked about directly and indirectly. For example, three participants chose the word card 'sex', but another participant addressed the topic more obliquely in talk about sexiness. Some worked their way systematically through the words, while others chose a word, such as 'relationship' that elicited long sections of talk, but which then encompassed other topic areas. There were no words that were not chosen or covered in the participants' talk. Words that

participants talked about that were not on the cards were: complacency; compromise; fun, laughing, enjoying life.

The interviews lasted from 45 – 60 minutes. After the interview, participants were given a debrief sheet (see Appendix A), reminded of their right to withdraw from the study, and were given a £5 gift voucher in thanks for their participation.

The audio recordings were transcribed verbatim using a play script format, and were anonymized during transcription. Pseudonyms were used, and names of places, or details that would allow them to be identified were anonymized or removed. These transcriptions formed the data for the analysis (see sample in Appendix C). The interview and line numbers are given in brackets after extracts in the analysis chapters; pauses are indicated by (.), each dot representing approximately 1 second; overlapping talk is indicated by [.

Ethics.

Both the British Psychological Society (BPS) *Code of Ethics and Conduct* (2009) and the university ethics guidelines were followed in the planning of the study, and ethical approval was granted by the Psychology Departmental Ethics Committee (see Appendix A). Guillemin and Gillam's (2004) division of ethical considerations into procedural ethics and ethics in practice provided a useful framework for thinking about the ethical issues involved in interviewing couples about health and lifestyle. The former includes the process of designing the study and obtaining ethical approval. In the early stages of designing my project, I met with a counsellor from Relate to discuss the challenges of interviewing couples. The counsellor recommended that I consider my skills and possible training needs in preparation for carrying out the interviews, and suggested that I reflect on my own assumptions about relationships prior to data collection and throughout the research process. I had formerly qualified as a registered nurse, worked as a teacher and student support officer, and also worked as a volunteer in a rape-crisis centre. While I had a lot of experience discussing sensitive topics with a range of people and in varied contexts, I had not worked with or interviewed couples before, and I followed the counsellor's recommendations to seek out some further training in active listening, managing difficult conversations, and conflict management.

The counsellor advised me that in her experience, talk about body image could potentially lead to distress or disclosures of abusive behaviours. She gave examples of how partners draw on thin, fit ideals of femininity and can put pressure on a partner to lose weight after having had a baby, for example. As partners or parents may have engaged in criticism or body shaming, talk about body image might evoke painful current or past experiences. While I prepared strategies for dealing with conflict or disclosure of an abusive relationship, should it arise, and included resources and appropriate debriefing for participants, the counsellor suggested that conflict or difficulties should not be considered unusual or problematised for couples, which was particularly relevant for Study 2 (see later section for a reflection on ethics in practice as it related to interviewing couples). In addition to planning for what to do if abuse was disclosed, and giving support information on the debrief sheet, reflection on this conversation prompted me to develop the word-elicitation format for the interviews. I was already aware of the potential for questions to reproduce dominant ways of thinking about bodies and relationships, and in the light of the Relate counsellor's advice, this method seemed to offer participants some choice about the content and direction of their talk.

Before moving on to talk about the aspects of the method that were common to both studies, including reflexivity, quality criteria, and analytic strategy, below I describe the design, participants and procedure for Study 2.

5.2 Study 2.

The findings of Study 1 pointed to the need for further, in-depth exploration of how couples negotiate discourse of healthy lifestyle within intimate relationships. The participants in Study 1 had constructed lifestyle change as fluid, effortful, and short-term (see chapter 6). These were interesting results, but I wondered if the short-term nature of their engagement in lifestyle change arose from a lack of urgency about health since they were relatively young and healthy. I wondered if couples who were living with their own or a partner's illness, particularly one associated with lifestyle, would talk about and manage lifestyle differently, especially in the context of neoliberal sense-making of diet and exercise as causative, preventative, and curative of illnesses such as CHD. I therefore developed the design

for a second and more substantial study to investigate how transferable were the findings of Study 1, by interviewing patients with a new diagnosis of CHD and their partners. People newly diagnosed with CHD are almost universally recommended to make immediate changes to diet and exercise, thus I could explore how they negotiate health in the context of an expectation to manage lifestyle change.

Design.

I developed a longitudinal, qualitative interview design, in which participants were interviewed once a month for three months following their own or their partner's recent diagnosis with CHD. The purpose of a longitudinal design was not to compare or measure how couples' management changed over time, but rather to explore how participants talked about and negotiated lifestyle over the period of their recovery. Given that my aim was to explore in some depth the complexity that the literature indicated was part of couples' negotiations of health, a longitudinal interview design seemed essential, allowing possibilities for couples to provide nuanced and multiple accounts. A further advantage in using longitudinal interview design became apparent during subsequent analysis of the interviews, in which it became clear that time, permanence, and change were salient in their discourses of healthy living, and the longitudinal design allowed me to explore that aspect of couples' negotiations of health and lifestyle change. The interviews, which took place in a market town and rural Welsh community between April 2014 and January 2015, were audio-recorded, and lasted between 30 and 90 minutes, with an average length of one hour. A total of 37 interviews were conducted with nine couples interviewed together and four people in long-term relationships who chose to be interviewed alone. Twelve couples/participants completed all three interviews, while one couple completed only one, and another couple completed only two because of health issues. One participant asked to be interviewed a fourth time, and one couple withdrew from the study after one interview.

Participants.

Twenty-two cohabiting partners who had been in a long-term relationship for at least two years were recruited to the study through the local NHS cardiac rehabilitation programme. I lowered the threshold of relationship length from three

years because I wanted to maximise recruitment to the study after having had to turn down potential participants to Study 1 who had been cohabiting for less than three years. Two years was still longer than the 12-18-month period of adjustment within early romantic relationships (Marazziti et al., 1999), and I considered it would provide sufficient experience upon which couples could draw. As it happened, relationship length was considerably longer than this, ranging from 15 to 50 years with an average length of 33 years. Nine couples chose to be interviewed together, and four male partners with CHD chose to be interviewed alone. All identified as heterosexual, all but three were of white British descent, and were aged from their early 50s to early 80s, with a mean age of 63 years. Figure 2 below presents their ages, relationship length, and work status.

Table 2. *Study 2: Participant Demographic Information*

Name	Age	Work	Relationship
Henry *	mid 60s	semi-retired skilled	32 years
Catherine	mid 60s	retired office	
Louise *	late 60s	self-employed professional	44 years
Dan	late 60s	Working professional	
Eddie *	mid 60s	Retired public service	30 years
Lily	early 60s	Retired public service	
George *	mid 60s	Retired professional	15 years
Susan	early 60s	Retired skilled	
Holly *	early 50s	Retired public service	26 years
Graham	early 50s	Retired public service	
Paul*	early 80s	Retired agricultural	50 years
Ellen	early 80s	Retired agricultural	
Tom*	late 70s	Self-employed professional	43 years
May	Mid 60s	Home maker	
Jack*	Late 60s	Retired skilled	20 years
Deb	Early 60s	Retired skilled	
Carl*	Late 60s	Retired public service	39 years
Elsa	Mid 60s	Retired public service	

Robert*	Late 70s	Retired skilled	45 years
Richard*	Mid 60s	Business professional	29 years
Alun*	Early 50s	Public service	27 years
James*	Early 80s	Retired professional	48 years

Note: * indicates partner who has diagnosis of CHD

Cardiac rehabilitation programme context.

The local cardiac rehabilitation programme serves patients in a wide geographic area in mid-Wales, including urban centres and rural areas. It describes itself as a ‘comprehensive, multidisciplinary, cost effective programme of recovery, self-management, and independence’ (Lewis, personal communication) and is aligned with the British Heart Foundation’s (2012) definition of cardiac rehabilitation as a ‘comprehensive exercise, education, and behavioural modification programme designed to improve the physical and emotional condition of patients with heart disease’ (n.p.). The local programme was established in 1996 to address a 42% hospital readmission rate following MI, a rate that was reduced by 30% in the first year of running cardiac rehabilitation classes.

Currently, the programme accepts referrals by doctors in primary and secondary care of patients with a new diagnosis of CHD. Between 2000 and 2006, 74% of patients referred actually started classes, and 69% completed, compared with national average of approximately 50% (BHF, 2015). All participants pay a reduced cost to attend the classes. In response to patient feedback (patients reported receiving an overwhelming amount of lifestyle and medical information following diagnosis), rather than have educational sessions after the exercise classes, the cardiac rehabilitation service holds an annual patient conference. As of 2012, the service receives between 600-700 referrals annually, has an open door policy to allow patients to continue to use the service after their 12-week programme if they wish, and they now offer 76 classes a month covering a variety of exercises (such as Tai Chi), at a range of times, and locations throughout mid-Wales.

Interview design and procedure.

After the NHS ethics application was approved (see Appendix B), the cardiac rehabilitation team leader sent letters of invitation (see Appendix B), to potential participants as they were enrolled in cardiac rehabilitation following their diagnosis with CHD. Potential participants returned a reply slip in a pre-paid envelope giving their contact details, which I used to arrange a visit to provide information about the study. Participants decided the time and location – either their home or a comfortable, private room on the university campus, and whether they wished to be interviewed individually or as a couple.

Since the focus of the interview was more directly upon lifestyle and lifestyle change in the context of CHD, a condition that is frequently attributed to lifestyle, I was concerned about the potential for questions to reinforce understandings of lifestyle as morally weighted. By inviting participants to talk about their pre- and/or post-diagnosis experiences of lifestyle in an unstructured interview, I hoped to elicit talk about their experiences, priorities, and concerns, and allow for unexpected findings, such as lifestyle change not being salient in their management of their illness and recovery. The interviews were planned to be as unstructured as possible, with tentative, open, and minimal questions so that participants were able to direct the content and direction of the talk, and so that they could avoid potential distress and topics that they did not wish to discuss (Kvale & Brinkmann, 2009). I prepared an interview-question schedule to map out the possible scope of the interview for the ethics application, and to provide a guide for me to elicit more talk if needed during the interviews. Questions related to whether and how the patient and partner had made any lifestyle changes, how they talked about diet/exercise/smoking, and what information they accessed in making changes (See Appendix B). The interviews began with an invitation to talk about lifestyle before and/or the diagnosis with CHD. Participants talked with very little prompting and they all began with the story of their illness and diagnosis. Since the scope of the interviews was almost always covered organically in the participant-led talk, I did not formally use the interview schedule, but I kept its questions in mind to follow up on points raised by the interviewees and to ask about points that weren't covered. For example, one question in the interview schedule asked where participants obtained dietary information and

advice. Most participants spontaneously talked getting information from the Heart Manual, the cardiac rehabilitation nurse, the media, or their GP, but if they didn't, and it seemed appropriate in the interview context, I asked them the question.

Debrief sheets were provided at the end of the interviews, participants were reminded of their right to withdraw, and were offered £10 to cover their travel expenses and time. Further interviews were arranged three weeks later via phone or email, so that most interviews happened at monthly intervals.

Interviews lasted between 30 and 90 minutes (with an average length of 60 minutes), and were audio recorded and transcribed. The audio recordings were transcribed verbatim using a play script format, and were anonymized during transcription. Pseudonyms were used, and names of places, hospitals, or medical details that would allow them to be identified were anonymized or removed. These transcriptions formed the data for the analysis.

Ethics.

Both the BPS *Code of Ethics and Conduct* (2009) and NHS ethical guidelines were followed, and NHS ethical approval was gained to undertake the study. Interviewing couples, particularly where a partner has received a recent diagnosis of CHD, raises several ethical issues. Consent to joint interviews must be mutual, and both partners' had the right to withdraw from the study protected. There is potential for joint interviews to cause or expose conflict and tensions between partners (Valentine, 1999), and since the interviewees may discuss sensitive medical information in interviews relating to lifestyle and CHD, maintaining confidentiality required particular attention. Talking about the diagnosis may be traumatic or distressing for both partners, while CHD's designation as a lifestyle disease can leave patients and partners open to fear of judgement and self-blame. I wanted to avoid an approach which implicitly or explicitly judged participants' relationships and/or their management of lifestyle change. To do this I drew on Guillemin and Gillam (2004), who identify two dimensions of ethical practice: procedural ethics, and ethics in practice, which I discuss below.

Procedural ethics.

The informed consent processes were developed in line with BPS for both Study 1 and Study 2, and NHS guidelines were followed and ethical permission was obtained from the NHS for Study 2. I undertook NHS good clinical practice training to prepare for the ethics application, to consider issues of informed consent, and for carrying out the interviews, and undertook further training in communication, listening and conflict management to prepare for the joint interviews. An ethical issue that arose related to the fact that my partner works in the cardiology department of the hospital from which participants were recruited. Although no face-to-face recruitment took place, in order to avoid any conflict of interest, a different member of staff (the cardiac rehabilitation team leader) identified potential participants from their medical records at the point that they were referred for cardiac rehabilitation and addressed the envelopes for the letters of invitation. No member of hospital or rehabilitation team staff was informed about which patients took part in the study. The personal connection to the cardiology department made me particularly aware of maintaining confidentiality by not discussing the interviews with anyone except my supervisor, and of avoiding the risk of patients being identifiable in the completed analysis. The high volume of patients who use the cardiac rehabilitation service, the wide catchment area, the anonymisation of patient details, and lapse of time between the interviews and write up of the study will all help to maintain confidentiality if hospital staff read the final study or any related publications.

During the interviews, I followed guidelines for consent, emphasising to couples interviewed together that consent was joint, and if one partner wished to withdraw from the study or have part or all of an interview deleted, I would comply with no questions asked. I was aware of the responsibility of taking people's time and energy following a serious diagnosis, and in some cases, surgery, and tried to pay attention to signals of fatigue or discomfort. I emphasised the normalcy and lack of blame if participants withdraw from research studies, reiterated this at each interview, and gained verbal consent at subsequent interviews. I contacted people in as unobtrusive a way as possible, and checked if they were happy to continue to participate each time I rang or emailed to arrange the longitudinal interviews. One couple did withdraw after the first interview. As stated in the participant information

sheet, I did not ask them why, although I was concerned about why they had withdrawn. The interview had seemed to go well, although a brief argument had arisen between the partners, and they disclosed that the partner with CHD also had some further testing, and possibly a further procedure to undergo. Either situation might account for why they withdrew, and although I reflected that at least the withdrawal process appeared to be functioning as it should, it suggested that my sample conformed to typical recruitment profiles in that those who are less well, and whose relationship may not conform to norms of harmony are less likely to take part.

Interviewing couples where a partner has received a recent diagnosis of CHD raises several ethical issues (Mroz et al., 2016). Consent to joint interviews must be mutual, and both partners' right to withdraw from the study must be protected. There is potential for joint interviews to cause or expose conflict and tensions between partners (Valentine, 1999). Talking about the diagnosis may be traumatic or distressing for both partners, while CHD's designation as a lifestyle disease can leave patients and partners open to fear of judgement and self-blame. I wanted to avoid an approach which implicitly or explicitly judged participants' relationships and/or their management of lifestyle change. A number of advantages and disadvantages have been identified within the literature for each interview format. In joint interviews, for example, individual perspectives might be harder to discern, and some participants might not feel comfortable revealing some aspects of their experience (Taylor & de Vocht, 2011). Conversely, participants may be anxious about what a partner is disclosing in an individual interview (Morris, 2001). Reflection upon the balance of potential for harm to participants guided a decision to give the participants the option of being interviewed alone or with a partner.

Although, it is not usually possible to know if tension arose after the end of the interview, the longitudinal design meant that participants consented to three interviews, which I hope indicated that the experience was not distressing, and allowed some follow up, which I found reassuring. Some participants commented on their experience of the interview as positive, saying that they had valued the experience of being listened to, and telling their story - 'unfurling' as one participant put it. However, conflict between partners did occur in one interview, as I reflect on in more detail below.

Reflexivity.

Reflexivity is a process that acknowledges the position of a researcher as a person studying other people and considers how the process of examining a phenomenon affects what is found (Gough, 2003; Harper, 2003). The etymology of reflexivity is turning the gaze back upon the self in order to position ourselves as researchers in relation to our work, and to account for what we produce in our findings (Law & Urry, 2004; Shaw, 2010). In the following section, I will give some examples of different ways in which reflexivity informed the development of the studies.

The first relates to Guillemin and Gillam's (2004) distinction between procedural ethics, such as the university or NHS ethics application and procedures, and 'ethics in practice', a micro-ethics of the happenings that characterise research practice, in the interactions between participant and researcher. The authors identify these as "ethically important moments" (p. 261), the unpredictable responses and events that occur in all types of research, and how reflexivity can be used to learn about and from those moments. One example of such a moment concerned the issue of partner conflict, which had been prepared for in procedural ethics. In one interview, a female partner expressed her fear and frustration at her partner's over-exertion, and her voice rose in anger. Her partner remained quiet. I had written in my ethics form that I would stop the interview should conflict arise, and offer to delete that part of the interview. In the event, I worried that if I offered to stop the recording, I would be drawing attention to her feelings as something negative or not within the scope of normal coupledness. As I debated, her anger dissipated, and the couple returned to their usual mode of speaking and interacting. I reiterated at the end of the interview that all or any part of the interviews could be deleted at any time, but both partners assured me they were happy for their data to be used. Reflecting on the moment later, I acknowledged the potential for distress in interviews which cannot entirely be eliminated by procedural ethics. I also reflected on the ways that supportive and positive relationships are normalised and idealised, while conflict is often assumed to be negative and dysfunctional (Gottman, 2014). I began to think more inclusively, considering how much relationships vary, not just between different couples, but at different times for the same couple. My discomfort

with my response to the couple's conflict, and my questioning of the categorisation of relationships as positive or negative formed a starting point for conceptualising intimate relationships in ways that do not impose stable, binary classifications and judgements, but which take account of the fluidity and complexity of affective processes and interactions.

The second example relates to a common focus of reflexivity, the importance of researchers identifying their perspectives, beliefs, and biases early in the research process so that they can be suspended or bracketed (Cresswell, 2000). But Walkerdine (1997) suggests that subjectivity cannot be eliminated, although it can be reflected on and used as part of the research process. The question of my beliefs and position in relation to the topic area of the studies was highlighted by an incident in an interview that related to scientific truth. I grew up in a working-class family, but through a university education and nurse training, present as professional and middle class. And even though I made clear my status as a student, and disavowed any medical or clinical psychological knowledge, occasional comments, such as 'as a psychologist you'll know all about this' indicated that participants saw me as having expert insights or status. In an early interview in Study 2, Richard (mid 60s, married businessman), was finding it difficult to stop smoking and lose weight as he'd been advised by his GP. He said that if someone could tell him whether making these changes would definitely extend his life by a considerable amount, he would be happy to make them, but if the difference could be measured in months, he would prefer to keep to his old habits for a shorter, happier life. My background as a nurse, the incidence of CHD in my own family (my father died at 52), and my reading for this research study meant that I felt as though I could have given him the answer to his question. I didn't say anything, though later I even wondered whether ethically I should have told him the findings of studies that have investigated the effect of lifestyle change on survival post-CHD. Richard had said that he had tried to research his question on the internet, but at the next interview, he said he had still not found an answer, nor had he asked the cardiac rehabilitation nurse or his GP. Gradually, I realised that he was not looking for an answer in the way that I had understood his question in the first interview, and came to see his question as part of a process of negotiating lifestyle change, an acknowledgement of a cost/benefit analysis, and a

construction of uncertainty that could never have been resolved by my telling him that patients can reduce their risk of a second cardiac event by up to 30% by making lifestyle change. The incident made me recognise the ordering of my own understanding of lifestyle and health, and prompted my search for a theoretical framework that encompassed these affective, non-linear processes and critical understanding of the limits of scientific knowledge.

In the following section, I consider the quality criteria that, in addition to the reflexive processes exemplified above, I used to evaluate the rigour of my research.

Quality criteria.

Silverman (2011) offers some guidelines for evaluating qualitative research, some of which overlap with Potter and Wetherell's (1987) quality criteria by which discourse analysis can be evaluated. I discuss my analysis in relation to Potter and Wetherell's recommendations, before considering some of Silverman's more general criteria.

Coherence.

Coherence in discourse analysis refers to the structure of the discourses as well as to how they achieve their functions and consequences. In Study 1, discourses of lifestyle as a joint endeavour, as a form of risk management, and as short-term and effortful were consistent among the participants. In Study Two, conducted among couples where a partner had been diagnosed with CHD, I found similar discursive constructions, orientations, practices and positions in relation to lifestyle, a coherence that reinforced the validity of my broad findings, though differences in the data arising from joint interviews in the second study also allowed more fine-grained examination of couples' negotiations of discourses and norms of both health and relationships.

Differences and divergent cases should not be smoothed out, however, to achieve a coherent analysis. Divergent cases should not be left hanging, unexplained or excluded because they do not fit with the rest of the data. The theoretical framework and the analysis should be able to account for and incorporate variations such as these into the argument, accounting for both 'broad patterns' and 'micro-

sequences' (Potter & Wetherell, 1987 p.170). Exceptions should be attended to as they are informative and can advance the conceptualisation of the phenomena. As an example from my data in Study One, Joe and Liz both conformed to neoliberal understandings of weight as a proxy for health. They both had a relative they designated as very overweight, and ascribed the uncle and father's ill-health to excess weight. They both constructed their relatives as lacking in self-care, and themselves as more responsible, aware health subjects as they regulated their diet and exercise to maintain a 'healthy' weight, and were active and thin. Despite their own youth, fitness, and engagement with managing their lifestyle, the subjectivities that arose from these positions and practices were not secure, satisfied, or happy as might be expected. Their accounts returned several times to their relatives, who evoked fear and distress, and a dread of ageing, illness and dying. Attending to this unexpected aspect of the data, was part of the process that led me to expand the analysis to include Deleuze's notions of assemblages and affect. Using Deleuze's concepts, their response to their relatives' weight could be mapped without disrupting the previous levels of analysis. If Liz and Joe, young and apparently healthy, nonetheless included these fearful figures in their as part of their understanding, experience, discourses, and practices of health (health as an assemblage rather than a single, bounded concept), we can understand their emotions as the registering of affects, the ways in which bodies affect and are affected by each other, producing unexpected, sometimes ineffable increases and diminishments in their capacities and powers of acting. Joe and Liz express both positive and negative emotions in relation to health, and Foucauldian-inspired analysis and Deleuzian philosophy can be combined to conceptualise and account for the multiplicity and paradoxes in the data.

A further coherence was established over the longitudinal design of the study, with three interviews taking place over three months of the recovery period, which allowed a revisiting of the participants' accounts and experiences, and the constructions and orientations that persisted in participants' talk and interactions.

Participants' orientation.

Participants' orientation provides a further means of determining validity in discourse analysis. Where I identify apparently incompatible discourses or positions in participants' talk, Potter and Wetherell (1987) indicate that there should be some recognition by the participants of that incompatibility, some discursive 'work' to repair, qualify, or resolve. George, for example, resists neoliberal discourses of agency and control in maintaining one's health when he draws on more fatalistic understandings of health as being outside such control in his statement, 'your name's on the bullet'. He demonstrates that this is a counter-discourse, in his immediate repair 'there are things you can do of course', to resolve the incompatibility, and access positive identities from both positions (stoical, brave, and fatalistic and a responsible, rational health subject).

Potter and Wetherell also suggest that new problems are created if the theoretical framework is correct. If, in my data, people are negotiating competing and conflicting discourses of both health and relationships, then this should create problems that they will have to manage, drawing on new understandings and transforming discourses to resolve impasses. For example, in Study 1, Lewis was caught in a dilemma. He had gained weight which he was anxious about. He recounted a time when he and his wife had dieted and exercised together and lost weight, and he expressed a desire for them to do this again. But he also constructed his relationship as a place of acceptance and lack of concern about appearance. He resolved this impasse by constructing the exercise they do together as primarily about closeness and fun rather than to achieve an acceptable appearance, and thus balancing responsible health identities with appropriate relationship values.

Generativity.

The final quality criteria Potter and Wetherell (1987) include is generativity, arguing that a sound analysis will lead to novel explanations and produce concepts that are fruitful for further research. The analytic process of this thesis pushed me to search for a conceptual framework that accounted for affirmative as well as negative experiences in couples' negotiation and management of health practices within long-term relationships. I found that Deleuze's process ontology and ethics offers a way

through impasses and dualisms thrown up by positivist and even some critical approaches. Clinicians and those who care for people faced with making lifestyle change could potentially benefit from a perspective that accounts for the unpredictability of patients' responses to lifestyle advice, removing the implications of rationality and responsibility that underpins moralistic judgements and the logic of neoliberal and some positivist approaches, and issue I develop in the conclusion in chapter 10.

Transparency and rigour.

Silverman (2011) makes recommendations about the transparency and rigour of qualitative research, including situating the literature within existing research, developing a sound epistemological and ontological basis for the approach, transparency in the processes of study design, data collection and analysis. My PhD supervision contributed to the rigour and transparency of the research process, as different stages from planning and gaining ethical approval were discussed and shared with my supervisor. The process of applying for university and NHS ethics required a justification for both studies within existing literature, and early analyses were shared with my supervisor and postgraduate colleagues, and presented at national and international conferences where I gained feedback from peers and mentors. I kept records including a reflective research diary (see sample extract in Appendix C), notebooks, annotated transcripts, analytic tables, earlier versions of analysis and write up. Reflective and reflexive processes informed the design of the studies and the analyses. I have set out the processes and decisions I made throughout the study design and analysis, and provide audit trails in the appendices.

In order to establish transparency in the process involved in data analysis, I set out details of my data analysis strategies in the section below.

5.3 Data Analysis Strategy 1: Foucauldian Discourse Analysis.

The theoretical framework in chapter 4 demonstrated the value of Foucault's concepts of power, knowledge and discourse in considering wider social understandings of health and the ways in which those discourses are adopted by individuals in their management of their health and lifestyle. FDA and critical

discourse analysis (Fairclough, 2013; Parker, 1992; Van Dijk, 1993) offer a method of examining the historical and sociocultural context and the discourses and knowledges upon which people draw in their talk about illness and health. This is in contrast to other traditions of discourse analysis which focus on the mechanics of how language is used to construct particular realities and ways of being (Wiggins & Potter, 2008; Arribas-Ayllon & Walkerdine, 2008). Different forms of discourse analysis all share the principle that language is not a reflection or mediation of reality, but does things as well as state things; making language constructive and performative rather than a path to inner, or hidden truth (Davies & Harré, 1992; Hook, 2001; Willig, 2008). Although often considered incompatible (Hook, 2001), Davies and Harré (1992). Riley, Thomson, and Griffin (2010) and Wetherell (1998) argue that these different traditions are interconnected in the ways that people both constitute and are constituted by discourse. ‘Multi-level’ or ‘synthesised’ approaches in discourse analysis are thus viable and potentially advantageous.

In looking at how social discourses of health and intimate relationships are jointly negotiated my initial focus was on Foucauldian concepts of power, knowledge, governmentality, health discourses and the production of health subjects, so FDA seemed most appropriate. But I also wished to analyse the ways in which they take up dominant health discourses in their day-to-day health interactions. Willig (2000), in her ‘discourse-dynamic’ approach, advocates the use of a dual focus in the study of health. Focus One is based on FDA, and explores ‘expert’ and wider social discourses that construct health, illness and health subjectivities, what Willig terms ‘the discursive economy within which individuals live’ (2000, p.553), such as the healthism and neoliberalism outlined in Chapter One. In order to explore the ways in which dominant discourses shape subjectivity and mediate experience, Willig advocates what she terms Focus Two, attending to the ways in which those dominant discourses are adopted or resisted in people’s everyday talk and interactions about health. The diversity of and contradictions within social and expert discourses of health are identifiable in people’s uptake of such discourses. Willig (2000) also draws attention to the ways in which they are not passively adopted, but resisted and subverted in lay talk about health.

Fluidity, both of constructs and health behaviour, is predicted, and discourse analysis offers a method of mapping the multiplicity and mutability that characterises human interactions (Fairclough, 2000; Willig, 2008). Applied to the issue of health, Foucauldian theories of subjectivity and language indicate that ‘people’s statements about health and illness are not an expression of their inner thoughts on the subject but rather the mobilization of culturally available explanations. This means that any one individual speaker is likely to draw on different and often contradictory arguments in order to make sense of their experiences in different social contexts’ (Willig, 2000, p.548). According to Willig’s (2000, 2008) dual-focus FDA, two dimensions can be identified in couples’ talk about their health-related practices. There are the ways that wider social and expert discourses shape what can be said, thought, and done in relation to health on a macro level, producing knowledge and subjectivity - what we understand by health, and what it means to be a responsible health citizen, for example (Hall, 1997). Secondly, the ways in which couples negotiate these discourses, the micro-level processes through which couples manage their health and healthy lifestyle in their day-to-day lives can also be explored. Foucault distinguished between broad, governmental ‘technologies of power’ and the ways in which those technologies are enacted in individual’s practices or ‘technologies of the self’ (1988, p.18), concepts that map onto these macro and micro level processes, and provide a framework for making sense of the ways in which couples adopt wider social discourses, folding them into their joint engagement in health practices.

Willig (2008) offers a six-step guideline to conducting FDA, which is based on Henriques et al.’s (1998) application of Foucault’s theories, and Parker’s (1992) 20-step guidelines for FDA. Her method also incorporates some elements from discursive psychology, such as action orientation (Davies & Harré, 1990; Wiggins & Riley, 2010), providing the multi-level discourse analysis that was most appropriate for my study that wanted to explore couples’ negotiations of health within the context of wider discourses. In the following section, I will outline these stages of analysis, describing both Willig’s guidelines of each stage and how I operationalised these stages with my own data sets.

Step 1: Discursive constructions of the object.

The process of identifying discursive constructions in the interview transcripts involved a process of familiarisation with the data. Interviews, transcription, and close, multiple readings of the transcripts produced familiarity with the data, and a sense of the overall narratives and interactions. In Study 1, participants' talk about embodied experiences within their intimate relationships focused unexpectedly strongly on health and healthy lifestyle. Talk about their efforts to manage their own and/or their partner's weight through regulation of diet and exercise dominated the interviews. In Study 2, the initial interview question asked about lifestyle, and the talk again focused on diet and exercise in the context of their or their partner's diagnosis with CHD. The discursive object was therefore healthy lifestyle and lifestyle change.

Step 2: Identifying discourses.

Willig states that the discursive object can be made up of different discourses which construct it simultaneously in different ways. In order to explore the different ways in which health and healthy lifestyle was constructed in the participants' talk, I carried out thematic coding involved identifying any statement or section of talk that related to health or intimate relationships. These initial codes were descriptive and as inclusive as possible to capture explicit and implicit references to and constructions of health. Examples of these descriptive codes include '*worried about partner's weight*', '*wants to exercise but doesn't*' and '*naughty food*'. At the next stage in the analytic process I began to identify the wider discourses which enabled particular constructions. For example, '*naughty food*' was part of range of codes that constructed food as risky, bad or dangerous, I brought these codes together to consider the way in which participants appeared to draw on discourses healthy lifestyle as a form of risk management, and health as a moral and civic duty; discourses that can be understood as enabled by wider regimes of governance such as neoliberalism.

A particular challenge were the multiple and sometimes contradictory discourses. For example, as noted above, one participant said, '*if the bullet's got your name on it there's nothing you can do*', which I coded as constructing health as beyond one's control. But almost immediately he said, '*well there are things you can do*'. Initially, I viewed this as a puzzling contradiction. The analysis, however, was a non-linear, iterative process. As I read more theory, returned to the data, and reflected on my early analyses. Rather than searching for the 'truth' of participants' experiences, I developed my understanding of these constructions as interactional between partners or between interviewer and interviewee in the next state of analysis. That is, the use of multiple discourses to construct the discursive object. The discourses I identified in Study 1 were: healthy lifestyle as a joint endeavour; healthy lifestyle as of risk management; and healthy lifestyle as fluid, effortful, and short-term. In Study 2, each of these discourses formed a chapter, as I explored in more detail the variability and patterns within each discourse, within which I identified the action orientation of the discourses.

Step 3: Action orientation.

Action orientation focuses the analyst on the interactional effects of the talk, it refers to the function of the discursive constructions, why particular discourses are mobilised at particular times and with what consequences. Action orientation involves strategies to manage stake, credibility and identity as discourses may be used to bolster legitimacy, and apportion blame or responsibility. To analyse the action orientation in my data, I noted that there were orientations to me or to the partner (in joint interviews), and I examined these sections of talk to explore how the speakers responded, and how the conversation shifted in response to those orientations. I also looked for other ways that stake, interest or accountability might be oriented to, for example, in identity claims (e.g. as a former athlete). I also noted the rhetorical devices that discursive psychologists highlight as suggestions of interesting action in talk, including extreme-case formulations three-part lists (Edwards, 1985; Pomerantz, 1983).

For example, the participant mentioned above drew on fatalistic and agentic discourses while talking about his wife's active engagement with healthy living and

his own less engaged approach. From this perspective, his construction of two apparently incompatible discourses can be seen not as a reflection of a conflicted inner state, but rather an orientation both to his wife and to me who, as a health researcher, might be expected to adhere to dominant norms of health behaviour. He also oriented to norms of responsiveness in intimate relationships. He did not dismiss his wife's concerns, but by drawing on more than one discourse, he also legitimized his own less than full engagement in lifestyle management. Qualitative analysis is an iterative method, and so this 'stage' was conducted more than once. For example, during a later stage in my analysis, once I had decided my main arguments and extracts used to present them, I returned to the extracts to reflect on the language used, and conducted a more detailed analysis of the action orientation. For example, how an extreme case formulation might be used to justify a subject position.

Step 4: Positioning.

Positioning involves the identification of the subject positions that discourses afford. According to Davies and Harré (1990), people are intelligible or recognisable to themselves and others according to how they inhabit the 'location' of a discourse. For example, in order to be recognised as an expert in relation to health knowledge, people conform to normative ways of behaving and talking, such as using scientific language. These positions shape and are shaped by what can be said in particular contexts. According to Davies and Harré (1990) people can be positioned in particular ways during interactions – as having or lacking authority, blame, or responsibility. People are also positioned in relation to wider social discourses when they draw on expert medical discourses, occupying more or less valued positions such as responsible or irresponsible health citizens. To identify these positions, I looked at my data and asked what kinds of people were evoked in participants' talk, what identities were claimed, how were these enabled by the wider discourses in the participants talk? Particularly in the joint interviews, I attended to shifts in couple interactions, and the rhetorical devices that were used in those shifts. In the example above, when George drew on discourses of fatalism, he also negotiated his wife's position as the 'health expert' in the relationship. He avoided being positioned as irresponsible or as an unresponsive romantic partner by validating his wife's knowledge and concern for his health as normative for a loving partner, and

attributing his lack of interest in lifestyle to a ‘different philosophy’, rather than irrationality or irresponsibility, thus maintaining a positive health identity by retreating from his assertion that ‘*there’s nothing you can do*’ to a more agentic and responsible, ‘*well there are things you can do*’.

Step 5: Practices.

In line with understanding discourse as social action, particular discourses ‘open up or close down possibilities for action’ (Willig, 2008, p.111). Discourses shape and are shaped by what can be done as well as said, and subject positions have attendant behaviours and practices. A responsible health citizen and romantic partner not only manages their own health, for example, but also legitimately engage practices of surveillance and scrutiny of others as well as the self. My process in identifying practices involved noticing talk about actions around food, exercise or their behaviours towards each other, other people, or objects. Looking at these practices I asked: What do these practices involve? Who can do them and how are they accounted for? What sort of ways are they linked to health or to constructions of intimate relationships? How are they linked to subject positions or the wider discourses I’ve identified?

Although Willig’s steps are presented linearly, as noted above, in practice, the process was iterative as thinking about these practices help me identify other subject positions thus contributing to previous as well as subsequent steps. For example, a loving partner subject position, as defined by someone who cares for the other, may also engage in surveillance, checking on the partner to make sure they are following health advice for example. However, as I argue in chapters 6 and 7, high levels of control potentially transgress relationship norms, and shifts ideals of equal partnership into dispreferred and/or unequal power relations. Couples may therefore monitor each other’s diet and exercise, but in examining the practices enabled by the subject positions they take up, I also map the ways that available positions relating to health and intimate relationships may involve competing and conflicting practices, such as sharing pleasurable food and relaxing together, which may contravene imperatives of health to exercise and regulate diet.

Step 6: Subjectivities.

This step involves exploring the subjective experience enabled by the discourses and subject positions. Willig acknowledges that this stage is more speculative, since the nuances of subjective experience may not be as available to the researcher as what is said and done, and assumptions cannot be made between ‘causal’ language and actions and what is felt and thought. A key aspect of subjective experience are emotions. Emotions can be related to subjectivities produced by these norms and power relations as people experience joy, sadness or disgust at their achievement of, or failure to achieve a desired relation, to understand themselves or be understood at belonging to a valued or unvalued position (Davies, 2013; Wetherell, 2012). To explore subjectivities, I paid attention in the data to when participants talked about emotions and was inclusive in my understanding of subjective experience, noting emotions but also any other descriptions of inner thoughts, moods or experiences. When identifying such subjective experience in the talk I interrogated my data by asking how these were produced or enabled by the wider discourses and subject positions being described or associated with these experiences in the talk? What do these subjective experiences tell us about how health and/or intimate relationships are being constructed? In chapter 7, for example, I consider the pride and satisfaction that Carl expresses in his exercise capacities when he compares himself favourably to younger men at the rehabilitation class. Carl positions himself as a responsible health citizen, designating less physically able patients as lazy or lacking in appropriate commitment. Despite these efforts, his blood pressure remains high, evoking intense anxiety in Carl and his wife, who worries that excessive exercise in the presence of high blood pressure may result in a stroke, an anxiety mixed with frustration and anger at Carl’s refusal to restrict his exercise.

In going through Willig’s (2008) six steps, often in an iterative process, as ideas on one stage might fuel new thinking in another, I was therefore able to build up an analytic landscape that articulated the way social discourses of health and intimate relationships were jointly negotiated that allowed me to see the way discourse produced particular subjectivities and practices, structuring what people could say, think and do in relation to their health status, intimate relationship and

engagement with lifestyle change advice. It allowed me to highlight the role of normalisation, disciplinary power/regulatory power, and to explore how people resist or take up dominant individualist discourses of health and healthism, while also incorporating the complexity of multiplicity of participants' sense-making. Positioning, for example, can be seen as involving the discursive construction of the object (e.g. healthy lifestyle as risk management), with the action orientation exemplified in participants presenting themselves as responsible and healthy, managing this position in interaction with a partner and/or the interviewer and in relation to wider discourses, systems of knowledge upon which people draw, such as neoliberal understandings of health practices as morally appropriate and rational.

Part of the process of doing the FDA outlined above involved developing large spreadsheets for each of the discourses so that I could be rigorous and systematic in my analysis, as well as see connections across the different participants' analyses and thus develop further depth to the process. At times, however, I saw 'moments' of talk that did not fit neatly into the developing analysis, but which seemed important to the research question. Amassing these at the bottom of the spreadsheet, and considering them collectively, they seemed to share a fluidity and multiplicity, representing parallel and contradictory discourses that exceeded my analytic framework. Much of this talk related to embodied experiences, materiality, and emotions, such as too tight clothes, rolls of fat around a partner's waist, sensations of chocolate and crisp eating or smoking, the push-pull of a cold, wet night and a warm sofa, fear, and hope as people navigate the actualities of their experiences, the affective gap between the promise and actuality of exercising and changing one's diet.

I discussed the salience of fluid, material, affective, and embodied experiences with my supervisor, who recommended I read papers by researchers who had used Deleuze's ideas. Although I found them very challenging, they seemed to offer the potential for exploring the ways in which the social is folded into individuals' lived experience, 'the *relational* processes of affective activity operating interpersonally...in all its potential messiness and contradiction' (Smith & Tucker, 2015, p.4). It was *A Thousand Plateaus* (Deleuze & Guattari, 1987) that clarified their conceptualisation of rhizomatic processes and assemblages with their

heterogeneous interconnecting dimensions, and I used these concepts to expand the ontological framework for understanding patterns in the data and to conceptualise the interactions and experiences that exceeded or resisted capture within the discursive framework.

The FDA analysis had helped me address my research questions, and had met the quality criteria outlined above. My reading indicated that it was compatible with Deleuzian methodologies (Deleuze, 2006; Ringrose, 2011), so I chose to develop it with Deleuzian analytics, in order to answer my research questions more completely, and in so doing, addressing quality criteria for the generativity of qualitative work (Potter & Wetherell, 1987). I also build on recent methodological developments that have used Deleuze and Guattari's concepts in qualitative social sciences research methods (e.g. Davies, 2013 Ringrose & Coleman, 2013; Tucker & Smith, 2015). Below, I outline how I applied Deleuzian analytics to my data.

5.4 Data Analysis Strategy 2 – Deleuzian Mapping.

My concern with FDA was that in systematically identifying discourses and the subjectivities and practices they enabled, I recognised that these discourses did not fully capture certain aspects of my data. What I also wanted to explore, evidenced in the 'moments' at the bottom of the spread sheet, was to attend to the intricate and unpredictable affective shifts that seemed to disrupt, even temporarily, dominant discourses and create new ways of understanding experience (Biehl & Locke, 2010).

Brown, Cromby, Harper, Johnson, and Reavey (2011) use Deleuze's focus on relations and events rather than an essential person or phenomena, and suggest 'beginning with the relations that makeup the action complex and then exploring how their combination affords particular kinds of experiences' (p.512). The question becomes not one of knowing or fixing knowledge, but of mapping relations. This does not mean that there can be no solidity to what is produced, but as Barad (2007) argues, researchers must take responsibility for the particular perspective or 'cut' that a researcher makes. For example, in the field of couples and health, relationships, interactions, and affects are usually designated as positive or negative, healthy or unhealthy. What is needed is an interrogation of these concepts and boundaries if

they are to account for the variability, complexity, and ‘messiness’ of couples’ experience. Law and Urry (2004) argue that research methods are ‘*performative*. By this we mean that they have effects; they make differences; they enact realities; and they can help to bring into being what they also discover’ (p.393-394). Researchers themselves are not transcendent in relation to these assemblages, but are themselves part of the affective, relational flows within an assemblage. This perspective underlines the political nature of research and methodologies, and the responsibility for accounting for what is produced through the process of research, and for exploring the potential of our research to perpetuate boundaries which might oppress, disadvantage or stigmatise others. The challenge is to understand that it is the research findings themselves which are pinned down, fixed and designated in particular ways, not the phenomena being so described.

Since there is no clearly established method of using Deleuzian concepts, below I describe the iterative and non-linear steps in the process I used to applying a Deleuzian mapping to the data from studies 1 and 2.

Discontinuities.

Deleuze and Guattari (1987) used a rhizomatic model to conceptualise the affective flows between bodies, which form decentred, unpredictable and non-linear processes. They suggested that mapping allows a way of following the unpredictable and novel becomings that are produced in the actualisation of the virtual. Applying these ideas, Alvermann (2000) studied the ways in which a public library was used, and found a starting point in Deleuze and Guattari’s (1987) concepts of rhizomatic networks that enable a mapping of the affects and fluid becomings that the space of the library afforded. Alvermann (2000) proposes that it is discontinuities in the data that required analysis, which in turn revealed rhizomatic patterns in the data which would not have been captured with more traditional methods whose aim is to look for coherence and homogeneity. She suggests that the openness and lack of beginnings and endings in rhizomatic thinking released her from a tendency towards ‘closure-seeking’ (p.125). She found the process of having no examples or clear method to follow challenging, but also ultimately freeing and generative.

Both the concept and the method of mapping enabled a rethinking of the data, especially those points that were troubling, problematic, or unexpected. These concepts were also useful to highlight and examine moments of transformation, for example, where my participants broke free from normative, neoliberal understandings of health and their attendant positions, to affirm something new, creative, and sometimes joyful.

Rhizomantic mapping.

Dimitriadis and Kamberelis (1997) developed the concept of mapping as Deleuze and Guattari describe it in *A Thousand Plateaus* (1987), by considering their distinction between maps and tracings: ‘a tracing is a reproduction of a world that is based on models of deep structure and a faith in their discovery and interpretation...maps are based on rhizomatic or essentially unpredictable articulations of material reality’ (p.149). They acknowledge that the researcher ‘works at the surface “creating” possible realities by producing new articulations of disparate phenomena and connecting the exteriority of objects to whatever forces or directions seem potentially related to them. As such, maps exceed both individual and collective experiences of what seems “naturally” real’ (p.150).

Using longer extracts, following sections of talk or patterns of interaction through an interview, or across the three interviews, I began to think rhizomatically in terms of affect and assemblage, looking at what was ‘happening’ in the data - what was enabled or blocked in the course of interactions between partners or between individuals and the researcher. I engaged in a period of experimentation with charts and diagrams, and many rewrites, as Alvermann (2000) also recounts, to begin to map some of the findings. I read literature that used Deleuze and Guattari’s concepts, and noted how people were using it. Closest to my study, in which I had already carried out FDA, was Ringrose’s (2011) study that use the combination of a Foucauldian discursive framework and a Deleuzian ‘mapping’, stating that she ‘explicitly build[s] on a discursive analysis...by exploring the effects of discourses circulating in social network and school assemblages, and how they operate to shape the affective capacities of bodies’ (p.602).

The concepts that make up Deleuze's metaphysics are themselves rhizomatic rather than independent elements. Becoming is a process produced by desiring machines of assemblages. Considering this work, I started to explore how elements of assemblages of love and intimate relationships are 'plugged into' assemblages of health, they create new virtualities, actualities, and relations. Through this process I started to build up a sense of what Deleuzian analytics would be most useful, coming to decision that I would use the concepts of assemblages, deterritorialisation and affect, and also Deleuze (1991) and Bergson's (2007) theory of time as a basis for considering temporalities of illness, health and recovery.

Assemblage, deterritorialisation, and affect.

Deleuze and Guattari's work has been used in other research, particularly the mapping assemblages and affects, as referred to in chapter 4. Ringrose and Coleman (2013) also showed the utility of this analytics when they based their method upon Alvermann's (2000) technique of attending to rhizomatic connections, and using the concepts of assemblage and affect to map the ways in which images and ways of looking at girls in online and offline spaces 'fix' them within dualisms of gender and sex, and how such fixities are not stable, but can be disrupted, or deterritorialised by 'life-affirming potentialities in assemblages' (p.129).

Affects, as outlined in chapter 4, are sets of often ineffable relations. They are not the same as emotions, which can be thought of as the body's registering of affects, and the evaluation of those affects as positive or negative, life-affirming or diminishing. In assemblages of health, discursive formations such as injunctions about diet and exercise territorialize and 'organise' bodies. This theory also elucidates the relationship between emotion and embodiment, in that affect relates to increases or diminishment in our capacities and powers through encounters with other objects, bodies or assemblages, while emotion is the recognition or marking of that affect. In applying the concepts of assemblages, affects, and deterritorialisation, I noted the moments of rupture, where dominant, utilitarian discourses of health as achievable through management of diet and exercise were transformed or deterritorialised. For example, for Liz (27, married postgraduate student) and her husband, lifestyle management was very salient, and she recounted that they

followed quite a strict diet and exercise regime. There were moments, though, when her constructions of securing health through control of lifestyle broke down. This happened in a way that produced negative emotions, fear and dread of aging and death, but she also reterritorialised utilitarian understandings of exercise and diet, taking an affirmative line of flight that evoked pleasure and hope.

Time and death.

Applying the concept of multiple durations was in some ways straightforward – I noted and coded sections where participants talked about time, and the apparent contradictions and discontinuities in their talk, in relation to illness, recovery, aging and death – but then had to identify, as Brown et al. (2015) recommend, what ways of being or modes of experience were afforded by those temporalities. This was complicated by the different ways in which death, for example, was talked about, often in the same interview. For example, a participant might construct death as fearful, and their diagnosis and treatment as a lucky escape, which warrants their engagement in lifestyle change. But when considering their lifespan and balancing the value of rigorous adherence to a healthy lifestyle, death might offer a more accepting, fatalistic standpoint, from which an anxious concern with avoiding pleasurable but risky food seemed futile. These apparent contradictions would have been difficult to resolve into a unitary narrative or health identity, but Bergson and Deleuze's concepts of the co-existence of present, past, and future, virtual and actual, and multiple durations of subjective experience, such as distinct but parallel time-frames of illness, recovery, and aging, allowed me to make sense of the multiple temporalities in participants' talk, and attempt to capture their vivid evocations of their experiences of time.

Reflection on the research methods.

The aims of this thesis included theorising and exploring the complexity and dynamics of couples' health interactions. Law and Urry (2004) suggest that, 'much of social life escapes our capacity to make models of it, not only in the technical sense that it is beyond the grasp of current research methods, but in the more profound sense that it is constitutively resistant to the process of being gathered together into a single account, description or model' (p.399). In addition, they draw

attention to the constitutive nature of research as, ‘methods are not only descriptive and generative but performative...methodology is a way of relating to multiply assembled worlds’ (Smith & Tucker, 2015, p.6), and so researchers themselves are not transcendent in relation to these assemblages, but are themselves part of the affective, relational flows within an assemblage.

This perspective underlines the political nature of research and methodologies, and the responsibility for accounting for what is produced through the process of research, and for exploring the potential of our research to perpetuate boundaries which might oppress, disadvantage, or stigmatise others. The challenge is to understand that it is the research findings themselves which are pinned down, fixed and designated in particular ways, not the phenomena being so described. Paula Saukko (2000) writes about the sometimes conflicting aims of respecting and attending to the experiences of participants and subjecting their narratives to critical analysis. She advocates being sensitive to the ways in which people and their stories can be captured, pinned down, by analysis. I have attempted to use poststructuralist approaches that recognise research as a constitutive process, acknowledge the fluidity and contingency of subjectivity, and offer an affirmative ethics upon which to base an analysis offer a path to thinking about, analysing and presenting people’s experiences in a respectful but rigorous way, that provides (admittedly contingent and situated) insights into those experiences. In the following four chapters, I present the results of the analyses I carried out on data from Study 1 (chapter 6), and Study 2 (chapters 7, 8, and 9).

Chapter 6: Joint ‘technologies of the self’

Introduction

The initial focus of this exploratory study was how people in long-term relationships talk about and manage issues relating to body image. The word-card task, described in chapter 5, elicited talk about appearance, but participants also recounted with great vividness their intricate and interconnected practices related to diet and exercise. Weight and fat were the words chosen or talked about early in the interviews by all the participants, highlighting the importance of this issue for the participants. Constructions of weight and fat structured participants’ talk about appearance and health, in line with the understanding of weight as a proxy for both. As I discuss in the analysis below, body image and being attractive to one’s partner and finding one’s partner attractive held some importance in the participants talk, but health. The intense engagement of relatively young and healthy partners in each other’s health-related practices influenced this thesis’ shift towards a focus on health and healthy lifestyle, but couples’ interconnected lifestyle practices were extremely complex, encompassing talk about appearance, health, and love. In this chapter, I explore how couples negotiate these parallel and sometimes competing, and sometimes conflicting discourses in their management of healthy lifestyle.

Beauty and health form individualistic discourses, but people in long-term relationships negotiate together the conflation of health and beauty in lifestyle advice and the fit, toned, thin ideal that extends to men and women (Evans & Riley, 2015; Malson et al., 2009; Gough, 2009). In this thesis, I argue that couples accept surveillance and management of each other’s health as a natural and psychologically healthy aspect of intimate relationships. In the internalisation and enactment of modes of government, subjectivities, and health identities, both individual and those constructed within intimate relationships, form part of a regulatory system (Crawford, 2006). The idealisation of couples who achieve a healthy lifestyle supports Rose’s (1999) argument that couple relationships are discursively constructed as ‘a key functional element in both our personal happiness and social efficacy’ (p.249). In a development of Crawford’s (2006) argument that ‘in a health-

valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices' (p.402), for couples in long-term relationships, the extent to which they fulfil ideals of relationships and health citizenship is a measure of both partners and the relationship.

Using Willig's (2008) 6-stage FDA, I identified three main discursive constructions in intimate partners' account: weight as a 'relationship thing'; healthy lifestyle as risk management, and healthy lifestyle as short term and effortful. In the first, couples construct healthy living, particularly relating to weight and weight management as a joint endeavour, which legitimised their surveillance and co-management of each other's diet and exercise. But these joint technologies had to be negotiated alongside intertwining and sometimes competing norms of appearance, health, and love. In the second, participants jointly negotiated dominant neoliberal health promotion and biomedical discourses which frame healthy living as risk management. Couples' engagement in each other's appearance and health can be conceptualised using Foucault's (1988) notion of 'technologies of the self', as they work not simply on their own selves, but upon their partners. Through such work, the relationship itself becomes a project – an ideal relationship that becomes visible through the appearance and health of both partners. Despite the interconnectedness of appearance and health, talk about health is not simply a proxy for beauty, but rather they form distinct discourses (Kwan, 2009), that are not only jointly engaged with, but must also be negotiated in relation to other discourses, such as those that establish norms of love and intimate relationships. Despite adopting understandings of considerable risk, however, in the final construction, participants disrupted health promotion of lifestyle change as simple and sustainable in their accounts of healthy living as effortful and ultimately short term.

6.1 'Weight...is a relationship thing': Joint technologies of lifestyle change

Across the data set participants constructed healthy lifestyle as a joint endeavour in long term partnerships. Understanding healthy living in this way positioned participants as neoliberal health citizens and also caring partners, which legitimised practices of surveillance, and co-management of diet and exercise, and

which put appearance and sexual attractiveness concerns as secondary. However, in line with contemporary health promotion and associated wider discourses, participants conflated health, weight and sexual attractiveness; while also understanding that relationships should provide places of acceptance and sanctuary from criticism, including those associated with health/appearance interventions. The outcome was that participants had to negotiate a set of complex, contradictory understandings and associated practices when understanding their health as a joint endeavour.

In the extract below, Liz (27-year old married student) constructed healthy living as integral to their long-term relationship:

Liz: it's a little bit about that commitment to stay together so um not not in terms of body image but by taking care of yourself you're kind of investing...in a long-termness (ll.104-108)

Above, Liz talked about her and her partner's engagement in healthy eating and exercise. She linked the '*commitment to stay together*' of long term intimate relationships with '*taking care of yourself*'. She explicitly stated that the need to take care of yourself for your partner or relationship was not related to '*body image*' and its associated appearance concerns or desire to be attractive, but to a '*kind of investing...in a long-termness*', which I read in the data as an orientation to health and the longevity it is expected to bring. In this extract, then, health and coupledness are tied together in a joint endeavour.

Liz's '*taking care of yourself*' articulated a neoliberal discourse of personal responsibility. But here, this individualistic discourse was transformed into concern for a joint future. Liz's health citizenship expanded to encompass her partner and relationship, in so doing, there was a conflation of health and coupledness. Health was tied to long-term outcomes, commitments, and expectations, since care of oneself would be rewarded by a long-lasting relationship as well as health. In using the term '*investing*' Liz echoed Hochschild's (1994) and Illouz's (2007) concept of neoliberal commercialisation. In this appropriation of the language of finance to her intimate relationship, Liz reinforced notions of healthy living and love as shaped by rational, cost-benefit decision making. From this standpoint, Liz rejected body image as a

reason to engage in healthy living in favour of values relating to health and relationship longevity.

In Liz's extract above, and across the study one dataset, participants constructed health as salient and an important shared practice for couples in long term relationship. Thus, by 'doing health' participants were also 'doing being a couple'. But this was not a simple process. As I show below, paradoxes and conflicts within and between obligations of health, norms of appearance, and those of intimate relationships, produce considerable complexity.

Although in the extract above, Liz explicitly rejected body image as a justification for lifestyle management, health and appearance were often conflated participants' talk. When discussing attraction, participants adopted social discourses that constructed beauty as key to attraction, and conflated beauty with weight (e.g. Tischner, 2013). They also articulated conflicting discourses of beauty.

Below, Elena (age 23, health-care worker and student, cohabiting) asserted the importance of appearance and sexual attraction in long term relationships, while also conflating health with attractiveness, and constructing health as a joint endeavour. Elena's extract is also interesting because, despite constructing relationships as a site where appearance and health matter, paradoxically, intimate relationships were also a place where norms of love and acceptance meant that there was less pressure to conform to beauty ideals:

Elena: I want him to be attracted to me and also I want myself to be attracted to him so I think uh he must uh well he he feels it as well that's why we sort of motivate each other I think to be healthy and exercise and if we fall off the wagon it's usually together (laughs) and then we climb back on it so I um also notice a little we are together only three years um you get you let yourself go a little bit I think ((laughs)) you do you don't worry about those extra pounds as much as when you don't have a partner (ll.195-199)

In this extract, Elena conflated being attractive with being healthy and taking exercise. Fitness and slimness were thus constructed as prerequisites for

attractiveness, and she drew on discourses that construct beauty and health as achievable through joint engagement in appropriate lifestyle behaviours. But despite the interconnectedness of their lifestyle practices, and the motivation to look attractive to each other, Elena also constructed long-term relationships as a space where appearance mattered less, producing a loss of motivation for weight management, '*you don't worry about those extra pounds*', where you could relax and '*let yourself go a little bit*'. Desire to lose weight was motivated by the promise of looking good or better, but at the same time, participants critiqued beauty ideals as unrealistic, shallow, and inauthentic. One way in which they resolved this dilemma was to problematise desiring beauty for its own sake, while making it acceptable as a means to increase confidence and self-esteem or by linking beauty with health.

Thus, desire to be slim and attractive was justified in terms of indicating adherence to a healthy lifestyle, and paradoxically, relationships were a place of freedom from over-concern with appearance. Below, Emma asserted the importance of attraction, but she also constructed healthy relationships as places of acceptance, that buffer against criticism and judgement about looks and weight from the outside world:

Emma: oh I know so many slim fit people who are so paranoid about the way they look and they already underweigh I've got to lose more I've got to lose more and I'm just like I'm sorry but life is not worth it as long as you feel healthy in yourself and happy in yourself it's just not worth it you know you're loved by someone and for who you are and I can't be doing with the stress of it ((laughs)) (ll.572-577)

Here, Emma transformed dominant discourses of weight as bad for health, and constructed the pursuit of thinness as bad for psychological health, and as indicative of a flawed relationship. In a relationship in which '*you're loved by someone and for who you are*', she resisted both over-engagement in health and appearance, and the connection between happiness, health, and thinness. Across the dataset, health was mainly talked about in terms of physical well-being with a strong focus on weight as an external marker for health, but here, Emma defined health

according to more individual, personal values. Her criterion was to, *'feel healthy in yourself'*. Focusing on this internal definition of health and on psychological well-being and functioning, she constructed intimate relationships as protective of mental health over and above shallow concerns with looks and weight.

Even those participants who resisted contemporary norms of grooming and beauty, and constructs their relationship as a place of acceptance, nonetheless oriented to discourses of fat as incompatible with beauty and desire. Emma, (46, public service worker, married with children) who elsewhere dismisses beauty ideals as unrealistic and inauthentic, for example, takes reassurance from her husband's continued desire for sex:

Emma: um (.) and it's just great you you're feeling stressed and ugly and horrible you know whatever and you've come home and your hair's a bit greasy and and then he turns over in bed and you're like oh yeah (laughs) ok he does fancy me whatever you know and it just makes you feel it goes beyond the physical just having sex

Int: [yeah

Emma: [part of it brings in that whole you he's you're still attractive to him you're still attracted to each other physically and and everything else and uh it it's just good (laughs) (ll.359-365)

Emma constructed sex and attractiveness as being important and as contributing to the relationship in her claim that its benefit *'goes beyond the physical ... and ... it's just good'*. Attractiveness to a partner was constructed as being about desire, but it also functional and therapeutic in that it increased self-confidence and provided reassurance about the relationship (Giddens, 1992; Illouz, 2007). Partners provided support for each other, a joint project that enhances the well-being of each. Although Emma's talk was structured by understandings of the need to meet normative ideals of attractiveness and sexiness, she disrupted these discourses in her assertion of her own and her partner's desire for sex and their attractiveness to each other, despite her own appearance differing from body ideals.

There is a conflict between neoliberal values of self-confidence - as seen in the 'love your body' discourses of postfeminism (Gill & Elias, 2014) - and powerful injunctions to manage weight which can undermine self-acceptance (Rauscher, Kauer, & Wilson, 2013; Schorb, 2013; Sykes & McPhail, 2008). Emma's extract above negotiates this dilemma with an individual decision not to '*be doing with the stress of it*' and instead, to enjoy the acceptance she experiences from being in a long-term relationship.

In other talk, this dilemma is harder to resolve, since participants were caught between health as a joint endeavour, and thus a need to support partner's 'healthy' weight management, and the norms of support and acceptance of relationships that can position weight criticism as hurtful, oppressive or abusive. This conflict is illustrated below, where Lewis' (age 47, married, public service worker with children) hesitated to talk about weight indicated potential for lifestyle management to trouble the relationship:

Lewis: a good relationship is some is a relationship where you can it's the unspoken word..that um gets you through a partnership so we we I guess we both agree to lose a bit of weight but it never really comes up ..being together a certain amount of time you you wh I accept Sharon for who she is and I'm sure she does accept who I am (ll.44-52)

Lewis constructed his relationship as a place of acceptance and support, and health practices as mutual and joint, '*we both agree to lose a bit of weight*', but the legitimacy of what can be said and done was situated within the context of other relationship values. The potential for criticism to cause distress or damage was signalled by Lewis' tentativeness and the importance he gives to '*the unspoken word*'. Lewis resolved this dilemma by choosing acceptance over imperatives of health. He minimised their need to lose weight, '*I guess*' and '*a bit of weight*', and acknowledged it as something they both need to do, deflecting, and disarming potential criticism by sharing the problem and its management.

Just as criticism is constructed as potentially violating norms of acceptance, autonomy and respect can be threatened by attempts to influence lifestyle

behaviours. In the extract below, Emma made explicit what her response to criticism would be:

Emma: you know I'm the sort of person that if he said ooh I think you need to go down the gym or something I'd be like sod you ((laughs)) don't you dare ((laughs)) I'm so I can't help myself

Int: yeah yeah

Emma: I have to do that rebelling thing and do the opposite of what 'cause I'm not keen on authority at the best of times [but

Int: [right

Emma: if someone tells me something um but I know if I wanted to do something I know that if I like sort of change and sort of control sometimes what we're eating he's completely supportive of it (ll.138-148)

Emma stated that she would strongly resist advice from a partner not, as Lewis implied in this extract above, because it would be hurtful, but because it would violate her autonomy and control over her health and lifestyle. Emma's account drew on discourses that place responsibility for health and illness upon the individual, and that situate solutions at an individual level too (Crawford, 1980, 2006). Personal responsibility for health can elicit guilt and blame, but Emma's reiteration of '*I*' and emphasis on her own agency positioned her as powerful and autonomous in her resistance of injunctions to exercise or lose weight. From this rebellious subject position, to be told to go the gym was thus understood as unacceptable, '*don't you dare*'.

Emma outlined a health interaction that was acceptable, one that is initiated by her '*if I wanted to do something*' but supported by her husband. Support rather than directive behaviour is thus constructed as meeting both relationship norms and health imperatives of weight management. For, although her control of their diet might seem to reproduce the power differential that she had resisted, she softened the force of her intervention with the modifiers '*sometimes*' and '*sort of*' which are less

direct and directive than the hypothetical advice to go to the gym. And the gym advice was aimed solely at her, while in her account, she controls ‘*what we’re eating*’, indicating a joint change on behalf of them both that echoes mainstream findings that bilateral lifestyle change is more acceptable to partners (Lewis & Butterfield, 2007).

Participants negotiated parallel and conflicting discourses of beauty. Beauty both mattered as a component in attractiveness and as a signal of interest in and concern with each other’s appearance, but conversely, relationships were constructed as places where acceptance of the other and of change means that appearance is of less importance, and provide a buffer against judgement and criticism for failure to conform to body ideals. Intimate relationships were paradoxically sites of joint work on the self, but also of sanctuary from such concerns, where partners were valued as they are and for who they are. Appearance was also constructed as diminishing in importance over time. The long-termness that Liz evoked necessitated an acceptance of change over time, and the extract below illustrates the hierarchy that participants constructed between appearance and health, in which health becomes a more salient and legitimate focus for couples:

Lewis: perhaps we should cut down on this and cut down on that um but I don’t know perhaps we’ve got to a point in our relationship where it doesn’t matter to us

Int: right

Lewis: I wonder if that’s what it is because we haven’t got a huge issue with each other’s size weight how we look and we’re happy together then I suppose the bit that when it comes round to health and healthiness um that’s the bit I think when you’re on oh getting older now I need to look after my body (ll.310-319)

Lewis built an account of a happy relationship as one where partners accept each other’s appearance and weight, and correspondingly, where there was no necessity to restrict their diet for appearance related sexual attractiveness. But the imperative of health did legitimise concerns about his body. Time worked both for and against lifestyle change in the context of his relationship, since the longer they were together, the less important appearance and weight became for him and his

wife. But he also adopted dominant discourses of declining health with age. Thus, despite his relative youth (he is in his 40s), Lewis constructed his age as making him vulnerable to ill-health. Below I explore partners' technologies of the self as they relate to health and healthy lifestyle, and consider the hierarchy they constructed whereby health formed a more legitimate basis for making or encouraging lifestyle change (Kwan, 2009), but which nonetheless sometimes threatened and remained subordinate to norms of intimate relationships.

As I discussed in chapter 1, an intense focus on weight in current health promotion constructs weight as a proxy measure of health, and individuals as responsible for their health (Bacon & Aphramor, 2014; Lupton, 2014). All the participants adopted this understanding of weight as a major risk to health, which then legitimised the surveillance and management of their own and partners' weight. This understanding of weight as a measure of health also gave rise to intense anxiety at times, as they drew on family histories to create fearful prospects of what could happen if couples did not 'keep an eye on each other' (*Liz, l.275*). Below, are two extracts in which Joe (a married 25-year old manual worker and father), made the connection between a male relative's excess weight and his ill health, tying both the weight and associated ill health to a lack of a long-term partner:

Joe: he's fifty-nine and he's had to go on disability now...and all because of his he he he isn't in a relationship (ll.641-644)

Joe: why get to that extreme when you've got someone telling you early on to do something about it you know (ll.31-32)

In the first extract, Joe established intimate relationships as powerfully protective of health; his relative's ill-health was attributed entirely to his single status, while the second extract focuses on the mechanisms of the protection a relationship gives, in that a partner would intervene 'early on' before the person reaches an '*extreme*'. Without the partner, Joe's relative was seen to fall into avoidable ill health, an outcome that Joe described at another point in the interview with vivid distress, where he associated his relative's weight with excluding the relative from any claim to self-esteem, describing the situation as a, '*disastrous mess...cause you've got to have some pride in yourself*' (*l.16*).

In Joe's and other participants' talk, weight was visible to a disciplinary gaze, an aspect of governmentality that judges, and bestows or withholds respect from others and the self (Foucault, 1988; Rabinow & Rose, 2006). To be overweight is to have visibly failed in the exercise of neoliberal values of responsibility, self-regulation, and investment in one's health. And what the present study shows is that for couples in long term relationships, this responsibility is extended beyond the self. Weight was thus not just the measure of good health citizenship, but also a measure of good coupledness.

Yet, despite the power of governmentality in producing understandings of the self and other, a complex and contradictory set of values were articulated in the participants talk. Joe, for example, constructed a hierarchy of values when, at another point in the interview, he implied that that a concern with health was less important than spending time with his family after work, *'I'm never never in before half past seven and I'm not going out again just to just to do that'*. In the conflict between his family values and desire for a healthy lifestyle, Joe described the importance of prioritising time with his family over going to the gym, while nevertheless expresses guilt over his failure to fulfil his responsibilities to improve his wife's diet and their lifestyles. The tying together of weight, good health citizenship, means that, unable to claim a healthy lifestyle, Joe understood himself not only as a failed self, but to be a contributor to a flawed relationship. Thus, while partners may have prioritised relationship values over imperatives of health and appearance, they still took on spoiled identities and the negative emotions associated with those identities.

In Joe's extracts above, he constructed weight as a measure of health, and as measure of a person in the sense that a 'healthy' weight represents an individual's ability to successfully manage their responsibility for their health-weight and keep it within cultural and health norms. In long-term couples this responsibility is extended to one's partner as well as one's self, so that an apparent failure in the partner to meet these ideal measures of health is also a failure in the self, and a sense in which the relationship itself is flawed. Yet, given the problems people have in dieting and maintain weight loss (Hunger et al., 2015; Pietiläinen et al., 2012), there is a high probability that participants' partners will not have a 'healthy' weight. How then do

participants make sense of their influence attempts, particularly if they are unsuccessful?

In the extract below, Hannah (a 31-year old public service worker, cohabiting with her partner) described struggling to support her partner who wanted to lose weight, but who resisted her encouragement to regulate his diet and exercise:

Hannah: I want to be supportive 'cause he he is actually he is overweight ((laughs)) there's no doubt about it and um y it's you know um I I don't want to be a mother (ll.11-12).

Hannah drew on dominant discourses that problematise weight (McPhail, 2009), which, within a discourse of health as a joint endeavour, legitimised her involvement in her partner's weight management. Support is understood here as support for his weight loss, and her partner's resistance to accepting her influence troubled her expectations of healthy living as shared and mutual. The maternal position she risked occupying has negative implications for their relationship with its connotations of an inappropriately dominant, caretaking role for her. The consequent infantilising of her partner risked denaturing and desexualising the relationship. In contrast to Joe, whose wife shared his aspirations and efforts even if they didn't achieve their lifestyle goals, it was clearly problematic for Hannah that her partner refused to engage in healthy behaviours and demonstrated a troubling inequality in their joint responsibility for each other and the relationship.

Participants' expectations of intimate relationships as supportive and accepting of lifestyle change attempts were sometimes frustrated, as in Hannah's extracts below where she described her and her partner's attempts to influence and resist each other's health behaviours:

Hannah: and I say well you know you're going to have to do some exercise and you know I say ooh let's join the gym or come and you know we'll go and play golf and and ooh it doesn't appeal it doesn't appeal he says and ((sighs)) (data cut) and so he he's not entirely honest about what he's eating and um then I

thought you know oh gosh is it make is this me making him feel bad about you know what he's eating (ll.33-55)

Hannah: yeah he wasn't particularly like supported of supportive of me running ...and um you know like I I did I didn't like to go out running when it was rainy and wet but I made myself but then you know I I'm quite weak ((laughs)) and I have have to have someone to propel me to do it

Int: yeah

Hannah: and he but don't go don't go (ll.296-306)

In the first extract, Hannah draws on understandings of exercise as a means of weight management (Malhotra et al., 2015) as she encourages her partner to exercise as a response to their concerns about his weight. Despite her presentation of the exercise as a joint endeavour, her partner resists her attempts to regulate his diet and exercise, and Hannah has misgivings that her efforts may have passed the boundaries of relationship norms of support and acceptance, and negatively affected him, '*is this me making him feel bad*'. The push-pull of their health interactions also undermines of her efforts to exercise. Her partner does not fulfil her expectations of appropriate support, and Hannah constructed him as actively as well as passively posing risks to their health, as well as not meeting her desire for a partner who encourages her to be healthy: '*I have have to have someone to propel me*'.

The above analysis explores participants' construction of healthy lifestyle as a joint endeavour and responsibility, in which couples normalised co-management of health, weight, and lifestyle within long-term relationships. Relationships were understood as protective of physical health. The couples extended neoliberal notions of individual responsibility to encompass each other's health, and particularly weight, in line with contemporary discourses of weight as a proxy for health and attractiveness (Aphramor, 2014 ; Lupton, 2014; Tischner, 2013). Partners adopted understandings of appearance as important, especially in the early stages of a relationship, but paradoxically constructed relationships as places of acceptance,

where appearance does not matter, where you can have greasy hair, gain weight, and wear sweat pants and still be loved and desired.

Although weight was a word chosen and talked about by every participant, their practices differed from and resisted the logic of dominant discourses of weight as unattractive and unhealthy. Participants negotiated the intertwined but distinct discourses of beauty and health alongside relationship norms of acceptance and support, constructing a hierarchy in which health was a more legitimate basis for lifestyle change than appearance, but in which both beauty and health were subordinate to relationship values. Although joint responsibility for health legitimised the monitoring and management of each other's weight, partners recognised that these practices had the potential to come into conflict with relationship norms, so that couples have to balance sometimes contradictory norms of health and relationships to maintain positive individual, relationship, and health identities.

Couples engaged in these joint technologies of the self in different ways. The participants normalised cooperative, equal engagement. In contrast one-sided or resisted health practices were troubling, reflecting badly on the partners and relationship. Weight management in particular disrupted understandings of relationships as sites of acceptance and support, and imperatives of health were balanced against other relationship and family values. Subject positions that were afforded by these different discourses included responsible health citizens, but also good romantic partners, for whom health imperatives were secondary to relationship norms and values of acceptance, support, kindness, and respect for each other's autonomy. These parallel, sometimes conflicting positions gave rise to a range of subjectivities and emotions. Failure to jointly achieve an appropriate lifestyle produced guilt, blame, and frustration, but good relationships were also constructed as a buffer against wider social discourses that create an intensified gaze on health and weight.

Within their broad construction of healthy lifestyle as a joint endeavour the participants also oriented to healthy living as a form of joint risk management. And in the following section I explore the positions, practices and subjectivities that this

construction of health as risk management afforded within their intimate relationships.

6.2 Risky relationships

As discussed in chapter 2, neoliberal regimes of governance produce a ‘risk society’ (Beck, 1992) in which the health is constructed through a ‘pedagogy of danger’ (Crawford, 2006, p.508), upon which participants drew in their sense-making around food. For example, sugary food, especially chocolate, was frequently constructed as a threat that required vigilance. Such foods were talked about as ‘junk’, ‘crap’, ‘naughty’ or ‘terrible’ (Emma, 1.38; Hannah, 1.81; Joe, 1.42), and as an ‘addiction’ (Liz.1.121). Participants positioned themselves as responsible health citizens, able to identify and manage risks through regulation of themselves and their partners, which legitimised practices such as the monitoring and joint management of each other’s weight and diet. But relationships themselves could also become risky if a shared lifestyle mitigated against a healthy lifestyle. Dilemmas also arose when partners had different perceptions of risk that produced differing levels of commitment to lifestyle change. Intense anxiety, guilt, and frustration could occur if either partner was seen to be failing to manage risk appropriately, or if expected support was not forthcoming. Thus, as with joint technologies of lifestyle, healthy living as risk management also had the potential to conflict with relationship norms and expectations.

Health identities thus extend beyond the individual to encompass the relationship itself, giving rise to evaluations and assessments based on its fostering of positive or negative health behaviours and outcomes. In failing to appear healthy through weight management or to claim a healthy lifestyle, partners risked identities as a failed health citizen, undermining their partners, and contributing to a flawed relationship. For example, in the extract below Joe is talking about his habit of buying ‘junk’ food - chocolate, crisps, and beer, which he associates with his partner’s weight gain:

Joe: *I’ve never had to go to the gym maybe one day I’ll have to but um uh what I bring home she it’s not really fair it’s not really fair*

Int: right so she

Joe: she'll eat what I'm having you see and she loves chocolate and she loves crisps and just like anyone else but because of the way I I just keep buying it (laughs) so so really that that's when we've both got to work together really I've got to do it buy it and keep it in the car or stop it altogether really

Int: and have you tried any of those things yet or do you just

Joe: yeah we try after a weekend off weekend off is when we say we can do whatever but um it always drags on ((both laugh)) to the next week I've got lagers in the fridge from the weekend off and I'll keep drinking them and that sort of thing but um I I'm pretty confident we always say that we're going to one day go exercising and all the rest of it I just don't know how how couples do that we want to do that we just can't ((laughs))

Int: just [time

Joe: [time is well I'm never never in before half past seven and I'm not going out again just to just to do that (.) so yeah I do see it as sort of my fault uh like (wife's) weight weight was up and down as my fault really (ll.56-78)

In the extract above Joe, constructed food such as chocolate and crisps as risky in relation to his wife's weight gain, and also the need to manage this risk as a couple, '*we've both got to work together*', wishing he and his partner could support each other better in the take up of shared health citizen subject positions and be the couple who '*go exercising and all the rest of it*'. In accounting for failure to enact his desire to live an appropriately healthy lifestyle, Joe negotiated the subject positions of good health citizen, who takes personal responsibility for following a healthy lifestyle, and a good romantic partner who supports and accepts his wife. Joe managed issues of culpability by locating risk management as his individual responsibility '*because of the way I I just keep buying it ... I've got to do it buy it and*

keep it in the car or stop it altogether really'. He deflected blame away from his wife, either by taking responsibility for bringing 'bad' food into the house, or by constructing her love of this food as normative '*she loves crisps and just like anyone else*'. Joe problematized his wife's love of chocolate and crisps in line with understandings of these foods as 'risky' (Benford & Gough, 2006), but he also normalised their universal appeal. By asserting that she is '*just like anyone else*', Joe shifted blame away from his partner, and showed the complex interplay between discourses of risk and relationship management.

In Joe's extract, food was constructed not just through a discourse of risk, but also of pleasure, creating a dilemma in which the couple managed the contradictory desires to both restrain food consumption and participate in its pleasures by indulging in pleasures on their '*weekend off*'. In this talk, Joe linked deliciousness with unhealthiness in a binary construction of healthy eating as unappealing (Mai & Hoffman, 2015). Delicious but 'unhealthy' food and alcohol were synonymous with relaxation, forgetfulness of risk and restraint, and the freedom inherent in '*we say we can do whatever*'. The '*weekend off*' was a time free of the restraint Joe and his wife wished to apply to their food consumption and, demonstrating how healthy living (constructed as restraint) conflicted with discourses and relationship practices in which food is a pleasurable shared experience. Sharing 'unhealthy' pleasures was an important aspect of this relationship, but it competed with Joe's construction of intimate partners' disciplinary role in keeping their loved ones within certain parameters of weight and therefore health.

For Joe, weight was a proxy for health, and he constructed a moral framework for his health practices when he condemned himself as at '*fault*', and '*unfair*' on his wife. Joint responsibility implies that couples manage not only their own struggles with self-control, perception of risk, and moral positioning but also their partner's. Dynamic patterns of control and release, restraint and pleasure (Roberts, 2006) give rise to complex subjective responses involving feelings of responsibility, anxiety, and guilt over a partner's weight and health. Joe was left trapped between two contradictory discourses in which lifestyle change was achievable and impossible: '*I'm pretty confident we always say that we're going to one day go exercising and all the rest of it I just don't know how couples do that*

we want to do that we just can't'. Rather than attribute failure to an unrealistic goal, he looked to his own lack of time, which in turn evoked self-blame, and positioned them as a less than ideal couple.

Not only do couples fail to achieve imperatives of health and ideal coupledness, but also construct the interdependence and connectedness of having a shared lifestyle as creating greater exposure to lifestyle risks. In the extract below, Hannah described how her intimate relationship increased her intake of risky food:

Hannah: I love chocolate but on the other hand I'm trying to be good and lose weight you know and um when we're going shopping in the supermarket he'll um you he'll like put something naughty in like profiteroles and um I'll take them out or I'll say do you really want these..but then he'll buy loads of them because they only come in a big tub of like twelve or something and then if you don't eat them within like a day or two they go really horrible..and so I end up helping him out eating them so I get it really frustrates me as well (ll.79-88)

Here Hannah focused on problematic aspects of their shopping and eating together as a couple. The moral dimension to good health citizenship was underlined with Hannah's conflation of being 'good' with losing weight. Within this discourse, Hannah built an account of chocolate and the high calorie profiteroles as risky, and their consumption as incompatible with good health behaviour. She positions herself as responsible and risk aware, demonstrated through practices such as warning her partner, '*do you really want these*', and attempting to remove the forbidden food. But her influence attempts were undermined by her partner, who picked up the profiteroles, and in spite of Hannah's efforts buys '*loads of them*', her extreme case formulation conveying a sense in which she was overwhelmed by the unwanted purchase. She attributed the over-consumption to factors beyond their control as they can '*only*' be bought in '*a big tub of twelve*', and she took for granted their desire to avoid waste. Such external factors however, were internalised, since it is the couple and the relationship that is faulty, and she expressed frustration with her partner and herself.

In Hannah's account their joint lifestyle practices began with her attempt to restrain their intake, but ended with her '*helping him out eating them*', as their different perceptions and management of risk undermined Hannah's management of her diet (in the extract above) and, as we've seen in previous extracts, her management of their diet as a couple. Other constructions of food and relationships are absent, such as affirmative accounts of eating together and sharing pleasurable food. In adopting discourses that construct the individual as agentic and responsible for health, Hannah attributed their failures to achieve a healthy lifestyle to her own and partner's personal weakness. Her distress and frustration over these interactions constructed a relationship that was not functioning appropriately, indicating that Hannah associated harmonious health practices with happy long-term relationships. The failure to manage risk appropriately was thus not only problematic in itself, but could also produce conflict and dissatisfaction within relationships, as it was understood as a failure to attain relationship ideals of compatible, harmonious, supportive joint health behaviours.

The extracts above also illustrate that the challenges of managing health take place in the context of commercial forces advocating certain foods as instrumental for relieving stress and pressure, and public health messages advising self-control (Robertson, 2006). Patterns of consumption and restraint play out dynamically in couple relationships, as their consumption affects and is affected by their partner's engagement in risky behaviours. The outcome is a spiral of control, self-blame, and anxiety that that neoliberal healthism produces (Crawford, 2004).

In this section I have given examples of how participants constructed health as joint risk management participants, and adopted and negotiated dominant discourses of lifestyle, especially food, as a risk to be managed. In line with their overall construction of health as a joint endeavour, participants idealised shared perceptions and management of risk. The outcome was that differences between partners produced complex negotiations, positionings, and practices in relation to risk. Participants faced dilemmas when partners resisted attempts to limit 'junk' and sugary food, and when their shared lifestyle involved risky behaviours. Cooking and eating together fulfilled relationship norms, but also posed risks of weight gain, while relaxing and coping with stress together also presented opportunities for

couples to eat unhealthy food. Healthism's 'pedagogy of danger' is based on a fear of illness and death (Crawford, 2006). Long-term relationships provided a reason to maintain health, but also heightened partners' fear of ill-health and death, creating a desire to change behaviours, but a sense that sustaining such changes was out of their grasp. In the next section, I take up the notion of stability and sustainability, and examine the ways that couples negotiate the fluid actuality of their health and healthy lifestyle in the context of dominant understandings of health as attainable, stable, and sustainable.

6.3 'Drift back into comfortableness': Healthy Living as Short-Term and Effortful

Health-promotion campaigns such as Big Fat Problem and Change4Life construct lifestyle change as permanent and as simple and easily achieved (Bacon & Aphramor, 2014; Lupton, 2014). In the interviewees' accounts, however, it is clear that although they have an awareness of risk factors and consequences for health, health behaviour is more fluid and dynamic than these dominant discourses suggest. In particular, lifestyle change in long-term partners' accounts was characterised as difficult to institute and particularly difficult to sustain. The participants mapped out a landscape in which their usual lifestyle includes a range of behaviours, both more and less healthy and an acceptance of a level of weight gain. Lifestyle-change attempts were constructed as short-term forays into more extreme healthy living; a diet or exercise routine was introduced, usually in response to a perception that they may have gained weight, followed by a return to previous behaviours, or as Lewis put it, a '*drift back into comfortableness*' (Lewis, 1.392).

Contradictions emerged between participants' adoption of discourses of health behaviours as stable and consistent, and their descriptions of more fluid understandings and practices. In response, participants expressed self-criticism or a sense of failure, and some contradictions remained unresolved. For example, participants oriented to lifestyle change as non-permanent even as they drew on discourses of consistent and rigorous adherence to diet and exercise regimes, as in Hannah's reference to a meal-replacement diet that she had been following:

Hannah: I haven't stuck to it particularly well and I was on it for you know diligently off and on for about eight weeks (ll.67-69)

Hannah made a negative judgement on her adherence to the diet, but her use of the contradictory ‘*diligently*’ and ‘*off and on*’ also constructs diets as fluid and lacking in permanence, since engagement in a diet can apparently be both consistent and inconsistent. In this extract, Hannah took personal responsibility and blame for not maintaining her diet and weight loss, as she adopted discourses that attribute weight to individual behaviour, self-control, and will power. The nature of a ‘diet’, however, is that it is different from one’s usual eating (Green, Larkin, & Sullivan, 2009). Since a diet is not ‘normal’ behaviour, it will not have the permanence or consistency of habitual practices. Hannah thus appears to orient to the ephemeral nature of diets, but without releasing herself from criticism for not sustaining the unsustainable.

As with other health-related discourses, constructions of healthy living as short term and effortful had implications not just for their individual subjectivities, but for relationship identities as well. Earlier in his interview, Lewis described with pride how he and his wife had lost weight before a holiday in order to feel comfortable and attractive on the beach. They gained the weight back after their trip, and several years on, there was a family celebration coming up. Although they were buying clothes for the event and he is aware of their weight gain, he distanced himself from being the ‘*kind of couple*’ who would demonstrate inconsistent lifestyle behaviours:

Lewis: You know and I think we’re both a case of take us as you find us I know there are a lot of other people I know who would go on this diet and kill themselves effectively and then as soon as the event is over it’s back to how they were and they can we’re certainly not like that in our relationship um...maybe a tiny bit (ll.506-511)

Here, Lewis established an authentic identity for himself and his partner, but rejecting the idea that they are the kind of people who would rapidly lose weight just to look good at a wedding. Instead he characterises his relationship in terms of self-acceptance and a lack of concern with the judgement of others in ‘*take us as you find*

us', an account that also draws on the idea of coupledness as a buffer against the outside world (Finn, 2005). Lewis's extreme case '*kill themselves effectively*' constructed diets as dangerous, and he also questioned the hypothetical couple's ability to sustain their weight loss. Lewis and his wife thus had a choice of troubled identities. They could engage in healthy living and acknowledge their desire to look good, but be criticised for their lack of relationship values and regain the weight anyway, or embody more authentic relationship qualities of acceptance and lack of concern for the opinion of others, but be positioned as irresponsible in terms of care of the self. Lewis argued for the latter as the preferred option, but then acknowledged ambivalence, claiming he was not like the authentic couple before suggesting they were '*maybe a tiny bit*'. Lewis negotiated the competing claims of health and appearance. Both were desired, but both could be understood as vain and inauthentic, and thus were subordinate to relationship norms and values. , but this extract illustrates some of the unresolved dilemmas and contradictions that arise when people orient to their ability to maintain and achieve good health as morally laden.

In the interviews, participants adopted discourses of lifestyle change as a stable state, easily achieved through dietary restriction and exercise, while simultaneously constructing their healthy living attempts as effortful, fitful, and fluid. These contradictions did not produce a re-evaluation of their assumptions about health and lifestyle. Instead participants associated the difficulties in maintaining healthy living with their own lack of consistency or willpower, or their joint mismanagement of their lifestyle, locating blame in themselves or their relationships. These findings support Crawford's (2006) argument that in a health-valuing society people will judge themselves and others according to their engagement in social practices of health. As shown in the present study, for people in long term relationships, this judgement is not just on themselves and separate others, but is extended to their relationship. Thus, the relationship is judged in terms of the facilitation or hindering of appropriate health practices, despite these health practices often being constructed as unattainable or not part of normal everyday life.

In *The uses of pleasure* (1990), Foucault argued that the problematisation of bodies and pleasure is a form of disciplinary power. The participants in this study negotiated such problematisation in competing injunctions of health and of

relationships, so that they were forced to oscillate between the demands of responsible health citizenship and relationship norms. These negotiations produce multiple, often contradictory discourses, positions and practices, and gave rise to a range of emotions. In line with Crawford's (2006) predictions, participants experienced guilt and blame, anxiety and fear, but they also produced new, unexpected, and often affirmative ways of being that broke away from the constraints and impasses of dominant understandings of health and healthy living. In these accounts, they asserted alternative values such as pleasure, happiness and enjoyment in their lifestyles and relationships that are not reported in critical health research. I explore these 'affirmative transformations' in the following section, turning to the philosophy of Deleuze and his collaborator Guattari to conceptualise the ways in which couples transform as well as adopt wider social health discourses.

6.4 Affirmative Transformations.

In their concept of assemblages, Deleuze and Guattari (1987), proposed that objects, bodies, and constructs are not singular and stable, but rather fluid and multiple, composed of material (spaces, technologies, and bodies) as well as expressive dimensions (identities, signs, meaning, affects and desires) (see chapter 4 for further discussion). Affects are understood as relations between bodies, both human and non-human, which can either increase or diminish capacity and power to act in the world, while emotions are the body's registering of such affects. Deleuze and Guattari (1987) conceptualise desire, rather than Foucault's notion of power, as the primary productive force of existence. They conceive of resistance as a transformation, a more or less temporary line of flight towards a more affirmative and joyful way of being, although lines of flight can also be destructive (Deleuze & Guattari, 1987). Thinking of bodies as situated within affective, material, and discursive assemblages of health and intimate relationships provides a starting point for mapping some of the dynamism between, the embodied experiences, affects and emotions, and the unpredictability and novelty they produce (Brown & Stenner, 2009).

Thinking with Deleuze and Guattari's ideas allowed me to make sense of some unexpected, complex, and affirmative moments in the data (see chapter 5), and

to conceptualise some of the couples' practices as joint deterritorialisations of dominant discourses. In her interview, despite their relative youth, fitness and engagement in a healthy lifestyle, Liz talked with sadness about death when contemplating their future elsewhere in the interview, the likelihood of her resembling her father whose weight she had constructed as a major threat to his health. However, in the extract below, Liz went on to reflect on her and her partner's exercise and future in a different, and opened up a new and more creative and affirmative way of being:

Liz: I think we both really value what our bodies can do and we don't want to give up on the idea we can make them do more in a way um capoeira which is quite an acrobatic martial arts [together

Int: [oh yes

Liz: and um and yeah there's sort of like I don't know (.) although I never get get very good at the acrobatics and things and I've started yoga as well it's this sort of like think you I might be getting older and older but I can still do more and more things which is cool and eventually that will drop off obviously but um it's sort of like wanting to do more of that kind of thing...exciting and yeah fun (ll.556-566)

Rather than the designation of bodies as fat or unfit that recurred throughout the interviews, Liz asserted a value for their bodies based on what they can do, not on how they look. She deterritorialised, or took a line of flight away from utilitarian and instrumental discourses of exercise and from fearful constructions of weight, illness and ageing. In an unexpected echo of Deleuze's words about what bodies can do, Liz connected with the embodied, physical pleasures of exercise, and positive emotions of excitement, achievement, and fun to envision an affirmative future for herself and her partner, even as they age. She was able to contemplate the changes that older age would bring as inevitable, but not as closing off possibilities of what their bodies can do, affirming increasing capacities in '*more and more things*' rather than constructing a deficit model of ageing. Elsewhere in the interview, Liz's reflection on her fears for her and her partner's future health brought her to tears, but

here the contemplation of her body's capacities and her pleasure in exercise led to optimistic, creative, and novel prospects, '*exciting and yeah fun*'.

As Tambouku (2013) argues, Foucault does include emotions and embodiment in his theory of subjectification, such as the happiness and aesthetic pleasure involved in technologies or care of the self. However, it is Deleuze and Guattari's concepts of affect, and particularly their understanding of happiness as fully-realised capacities to connect and act which provide a framework for exploring pleasure and hope in couples' accounts of shared lifestyle and health practices. In the extract below, for example, I show how thinking with the concepts of affect and assemblage can illuminate the complex relations between love and health. Lewis recounted the pleasurable activities that he and his partner enjoyed, cycling or hiking to local pubs where they drank beer before cycling or walking home:

*Lewis: last summer we went through and it's continued thankfully
(coughs) through this phase of real closeness real
togetherness um um and we went to the agricultural show and
bought a pair of walking boots together how romantic is that
((laughs)) matching walking boots um and last summer we did
a lot of walking so we walked from um Westlea to Woodford
got the train back of course but we we took a packed bag with
us with some refreshments you know some cans of lager and
had a goal of getting to Woodford [data cut] it was a beautiful
day [data cut] it's a goal to get to we have to cycle back after
but a real sense of fun*

Int: yeah [yeah]

*Lewis: [I think that's what holds our relationship together is a
sense of fun and laughing and enjoying life
(ll.125-156)]*

In contrast to the effortful, onerous constructions of exercise that were common in participants' narratives, such as Lewis' own designation of a spinning class he had attended as '*torturous*' (l.360), here, Lewis recounted enjoyable

experiences of togetherness, happiness, and physical pleasure in exercising, eating and drinking. In these experiences, affective flows between assemblages of health and of intimate relationships formed affirmative relations in practices which increased their connectedness as a couple, as well as fulfilling some imperatives of healthy living. Their purchase of matching hiking boots reinforced constructions of healthy living as a joint endeavour, but here the imperative '*we have to cycle back after*' was balanced with '*a real sense of fun*'. Rather than discourses of functionality and control constructing relationships as instrumental to improving health or managing each other's health behaviours, the relationship itself had primacy; their enjoyment in their walking and cycling contributed to their '*real closeness real togetherness*'. They accessed joy and pleasure which sustained the relationship and transcended the constraints of the cognitive, rational, cost-benefit analyses which dominate contemporary discourses of diet, exercise, and healthy living.

Deleuze and Guattari's philosophy encompasses embodiment as well as affect, and so can be used to map materiality and sensory experiences. Mainstream health psychology and health promotion constructs eating as a cognitively-determined behaviour, and neoliberal health discourses place eating within risk and moral frameworks, where self-restraint and self-control are required for appropriate consumption, while delicious or desirable food is hailed as unhealthy (Mai & Hoffman, 2015). These understandings of food, dietary regulation and weight dominated the participants' talk about health and lifestyle, often in terms of distress, discomfort, conflict, fear, and failure. Affirmative or untroubled sensory and emotional aspects of eating were rare in their accounts, but an exception to this is the way that Liz talked about a shared foray into healthy eating:

Liz: we're like ok we're cutting out sugar right so we're doing this ((laughs)) crazy thing as an experiment for ourselves ... it was no grain or something or get off addiction to carbs....loads of eggs and cheese and loads of vegetables...you had to put in a lot of cooking and planning and everything like that but it was um it was really interesting I did feel like I was quite healthy at that time and you really appreciated food and things that never tasted sweet before tasted sweet then... we talked a lot about you know sort of how we

were feeling and uh ((laughs)) um yeah and so it was quite good to have that kind of connection (ll.114-141)

The three discursive constructions of healthy living I identified in the Foucauldian discourse analysis above are discernible in this extract. Health as a joint endeavour is evident in the couple's joint engagement in experimentation; health as risk management in the construction of carbohydrates as risky, even toxic, through language relating to drug addiction; and healthy living as short term and effortful, since despite its health benefits, the diet was a '*crazy thing*' '*an experiment*', not permanent or normalised. But Liz does not construct the ephemeral nature of the diet as a failure; despite acknowledging the pressures of time, cost and effort in bringing the diet to an end, it was a stimulating experience.

By terming it an '*experiment*', Liz oriented to the diet as creative and uncharted as well as short-term, with the possibility of unexpected results. Contributing to an affirmative account, she related intense embodied experiences, such as the vividly conveyed heightening of sensation of sweetness and appreciation of food, as '*things that never tasted sweet before tasted sweet then*'. The shared diet created further possibilities for connectedness and communication which she recalls with pleasure as Liz and her partner shared and talked about the diet and their feelings. By attending to her account through the lens of Foucauldian and Deleuzian concepts, the analysis of this extract can thus be extended to include the affective, embodied and relational aspects as well as the discursive construction of dietary change in Liz's account. Deleuze adopted Spinoza's proposal that the complexities of affects between bodies means that rather than being intrinsically good or bad, 'the same object can agree with us in one respect and disagree with us in another' (1970, p.33). This concept accounts for the ways in which dietary regulation and exercise can be experienced affirmatively or negatively by different people, or the same people on different occasions, giving rise to multiplicity and contradictions which defy simple resolution.

6.5 Discussion.

In this chapter, FDA was applied to the Study 1 interview data with relatively young, healthy people (age range 23-48) who were in a long-term relationship. The

aim of this exploratory study was to address a gap in the literature relating to how couples talk about managing healthy lifestyles, given the individualistic framework of health promotion and healthism discourses. I examined the ways that these participants made sense of their health in the wider context of individualistic, neoliberal, risk-focused discourses, and the consequences for partner's subjectivity and practice. I identified three main discursive constructions in intimate partners' account: healthy living as a joint endeavour, healthy lifestyle as risk management, and healthy lifestyle as short term and effortful. In the first, 'weight is ...a relationship thing', talk and practices relating to health and appearance converge in discourses of weight and weight management as a joint endeavour, which legitimised their surveillance and co-management of each other's diet and exercise. But these joint technologies had to be negotiated alongside intertwining and sometimes competing norms of appearance, health, and love. Within the broad construction of health as a joint technology of the self, participants oriented to relationships as protective of health, but also as a source of potential barriers to healthy living, as couples could share both positively but also negatively perceived health behaviours. Relationships were characterised by norms of acceptance and support that had the potential to conflict with neoliberal imperatives of health, and participants recounted practices which dynamically balanced the competing demands of responsible health citizenship and intimate relationships.

Across the data set participants focused on weight that formed a nexus of discourses of health as well as appearance. Participants negotiated intertwined but distinct discourses of health and beauty by accounting for appearance as something that both mattered and did not matter and constructing a hierarchy of values where health was a more legitimate concern for partners than beauty; and in which relationship norms superseded concerns with both looks and health. The outcome was that beauty, through its proxy of leanness, was recognised as instrumental in attraction and desire, but participants constructed ideal love as one that outlasts and goes beyond outward appearance.

Within intimate relationships, there was also the possibility for criticism of beauty to contravene relationship norms of acceptance, trust, fidelity, and long-termness that was characterised as involving an acceptance of physical change over

time. Intimate relationships were paradoxically sites of joint work on the self, but also of sanctuary from such concerns, where partners were valued for who they were and as they are. Couples negotiated these contradictions as they strove to maintain positive identities as partners and health citizens. Ultimately, they established a hierarchy whereby appearance was subordinate to health, and despite its importance, health was subordinate to relationship values of acceptance and love.

Within the context of their construction of health as a joint endeavour, couples engaged in healthy living as a form of risk management. In line with dominant discourses of health that focus on food consumption as part of managing a 'healthy' weight, couples constructed diet as a risk to be jointly managed. Understanding food as a risk to be managed legitimised the regulation of the amount and type of food consumed by both partners. Mutuality and support were features of this joint regulation, and failure to provide or receive such support gave rise to guilt and frustration. The fear evoked by contemporary understandings of weight as a major risk to health was salient in participants' talk. Despite their relative youth and health, participants' perception of risk centred on weight, so that even slim, fit young people articulated a sense of dread for overweight future selves. The fear that a lack of control over weight would lead to early illness and death added an impetus to their concerns about health which might otherwise be surprising in active, healthy people whose ages ranged from early twenties to late forties.

In contrast to discourses that promote health as simple, achievable, and sustainable through rationally chosen lifestyle behaviours, couples in this study negotiated healthy living as fluid, effortful and ultimately, short term. The conflicts couples negotiated had implications for their relationships, as successful lifestyle management was constituted as indicative of a happy relationship. As with risk management and the construction of health as a joint endeavour, an inability to initiate and sustain diets or exercise regimes were failures which reflected on individual identity as well as their functioning as a couple, evoking blame, guilt, and frustration. Further, attempts at weight loss for appearance concerns were associated with inauthenticity, so that regardless of how healthy lifestyles were constructed – in terms of healthy or appearance concerns – they could not be taken up easily.

Participants constructed engagement in a healthy lifestyle as a joint endeavour and their concern for and investment in each other's health as a relationship norm. Health-related practices, including surveillance and co-management of diet, for example, were performative of participants' coupledness, and were legitimised by neoliberal understandings of health as achieved through engagement in healthy living, particularly management of weight, diet and exercise. Foucault's concept of 'technologies of the self' contains a reference to joint or co-practices of self-improvement, as he argued that through processes of normalisation and surveillance, people are brought to 'effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and a way of being' (Foucault, 1988, p.18). I found support for the notion that such technologies can be joint in participants' accounts of working on their partner as well as themselves 'so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (ibid.). Foucault here acknowledges that others may contribute to this work on the self, but this analysis reveals a kind of shared or merged self, which partners work on in complex ways to produce subject positions of both good romantic partners and responsible health citizens. Foucault's notion of 'technologies of the self' is developed to encompass this blurring of the self and other through the performance of coupledness through practices related to healthy living.

Crawford (2006) argues that in 'a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices' (p.402-403). I suggest that Crawford's conceptualisations of individuals' health identities can be extended to also encompass couples' health practices. The findings of this chapter demonstrate that the partners defined not just themselves, but also their partner and relationship according to their success in maintaining appropriate health practices and subjectivities. Failure to achieve ideals of health behaviour was attributed to personal flaws, but also implied shortcomings in the relationship itself, and gave rise to anxiety and blame, frustrating the normative expectation for relationships to be harmonious and equal (Dryden, 1999). Despite the range of factors which influence the type and amount of food and exercise that people take, it was noticeable that the participants attributed these behaviours

exclusively to their own agency and choice, and to their own, their partners' and their relationships' individual characteristics and qualities.

This internalisation of health behaviours reflects Rose's (1999) argument that the surveillance and management of each other's health has come to be understood as 'natural' and a psychologically healthy aspect of intimate relationships and responsibilities. As couples and families internalise and enact regulatory contemporary healthism norms, they understand themselves and their partners and children in relation to expert, scientific discourses of normal, desirable functioning. However, biomedical and critical health literatures have revealed deep contradictions and inconsistencies in neoliberal health discourse and practices (Aphramor, 2005; Jou, 2014; McGill, 2014), which were articulated by the participants in Study 1. For example, understandings of lifestyle change as simple to achieve and maintain were disrupted by the participants' accounts of short-term forays in to lifestyle change, such as Hannah's sticking to her diet '*diligently off and on for about eight weeks*' and Lewis' '*drift back into comfortableness*' after their efforts to exercise and eat more healthily. Furthermore, for the couples in this study, this failure to maintain lifestyle change was not attributed to flaws in assumptions and information about healthy living. Not only did participants assume failed health identities on their own behalf, but also understood a lack of adherence to imperatives of healthy living to be indicative of dysfunction within the relationship, and a source of trouble and distress. In this way, health practices produce and make visible the boundaries and nature of romantic relationships, and these findings support critical perspectives of romantic relationships as sites of regulatory practices (Finn, 2005, 2010; Rose, 1999).

Study 1 thus shows the utility of FDA in showing how participants negotiate complex and contradictory discourses of good health citizenship and good coupledness. However, as discussed in chapter 5, some aspects of the data were not easily incorporated into the FDA analysis. To address this issue I turned to Deleuze and Guattari's concepts of affect, assemblage and deterritorialisation which allowed me to explore some of the ways the participants transformed wider discourses in which they were located. Deleuze's philosophy conceptualises health as a complex, multiple, dynamic assemblage rather than a stable state which can be achieved and maintained through simple, rational lifestyle decisions and choices (Duff, 2014).

Deleuze and Guattari's philosophy also provided tools which I could use to map dynamic and affirmative processes involved in partners' transformation of dominant health discourses. For example, I argued that thinking of intimate relationships as assemblages accounted for their complexity and dynamism, and the potential for health practice to produce affirmative and negative relations and affects for people in long-term relationships (Braybrook, Robertson, White, & Milnes, 2014; McLean et al., 2014).

Assemblages are transformed in the process of becoming ill or becoming well, but the maintenance of health through engagement in lifestyle practices is a fluid middle ground between wellness and ill health (Farrimond et al., 2010). Vigilance, discipline and agency are required to avoid slipping into ill health, and conformity to norms is morally laden (Riley et al., 2008). The 'pedagogy of danger' (Crawford, 2006) that permeates current understandings of health adds to the potential for health imperatives to impose on relationship norms, positioning partners in negative ways, either as controlling or irresponsible in relation to their health. But participants in this study also took occasional 'lines of flight' away from purely regulatory and utilitarian health discourses, producing new, affirmative, creative ways of being, characterised by joyful emotions, pleasure, and optimism in a deterritorialisation of the over-coded spaces of both relationships and health. As such these accounts disrupted the 'scripts, rituals, institutions, and conventions through which couples' possibilities are simultaneously formed, enabled and constrained' (Finn, 2005, p.273).

Despite their relative youth and health, the accounts of study one participants thus demonstrated considerable complexity in their negotiations of lifestyle advice. Study 1 also demonstrated the power of healthism, in particular its association of health with agentic lifestyle choices, in structuring the subjectivities of healthy people. The significant question that therefore emerges from study one is what happens when people are not able to claim healthy identities, and who are thus directly under the disciplinary gaze of neoliberal healthism? To I address this question I use the following three chapters to examine the ways in which couples talk about and manage healthy living and lifestyle change in the context of ill-health after one partner has been newly diagnosed with CHD.

Chapter 7: Ideal health citizens, ideal partners.

Introduction

In the previous chapter, partners' constructed health and healthy living as a joint technology of the self, and took for granted an intricate involvement in each other's lifestyle. Despite their relative youth and health, participants adopted discourses of intense risk, with healthy living as highly protective of health. Weight management through diet and exercise formed a nexus of discourses of health and appearance, with weight a proxy for both. Participants constructed a hierarchy of values in which appearance was contested; they negotiated intimate relationships as sites where beauty and attraction mattered, but also as sanctuaries from pressure about appearance. Concerns about a partner's health were more legitimate than concerns about appearance (Kwan, 2009), but both were subordinate to relationship norms of love, support, and acceptance. Their joint technologies of beauty and health had important implications for subjectivity in terms of how individuals felt about themselves as individuals and partners as well as their relationship.

Mainstream couples' health literature establishes good relationships as those that promote health and well-being. Attachment theory, for example, proposes that caring and nurturing are adaptive, evolved, biologically-based behaviours within adult romantic relationships (Hazan & Shaver, 1987). In contrast, socially constructed theories of love consider that sociocultural norms shape the practices and subjective experiences of love (Beall & Sternberg, 1995; Simon, Eder, & Evans, 1992). Thoits (2004) argued that emotion norms, such as those relating to romantic relationships, are sociohistorically and culturally contingent, so that they produce social order through pressure to conform. The normativity of health and relationships that I identify in this thesis is compatible with the wider poststructuralist approach in Bronwyn Davies' (2013) account. She builds on Foucault's (1980) and Butler's (1993) concepts of normalisation to consider the emotions that are connected with fulfilling or falling short of valued identities (see chapter 4). Participants evaluated themselves, their partners, and their relationship according to how well they fulfilled sometimes competing norms of health and intimate relationships.

This chapter moves both mainstream and critical literatures forward by demonstrating the complexity and dynamism that arises when sometimes competing norms of health and of relationships are negotiated in couples' health practices, in ways that structure subjectivity as well as practice. Meeting norms related to health and relationships were important for participants in Study 1, but these norms were not always in alignment, and there were contradictions within as well as between discourses of health and relationships. Participants' difficulties in maintaining normative or idealised health and relationship practices produced anxiety, and distress, despite their relative youth and health. In this chapter, I report from longitudinal interviews with couples to explore how they talk about their management of healthy lifestyle and lifestyle change advice when a partner has been diagnosed with CHD.

In line with the method of analysis outlined in chapter 5 and applied in the previous chapter, I use Foucault's (1988) notions of normativity and technologies of the self, and Deleuze and Guattari's (1987) concept of assemblages to explore how the couples drew on an overarching construction of health as a joint endeavour, which formed the context to their experience and management of illness and lifestyle change. The salience of a partner's diagnosis with heart disease, and the longitudinal interviews elicited depth and range in couples' talk about their intricate and elaborate technologies of lifestyle change in the context of serious lifestyle disease and medical advice to make lifestyle change by increasing exercise, smoking cessation, and modifying diet. Overt talk about appearance was absent in this data, though the couples in Study 2 still took for granted that intimate relationships are sites of health-promoting practices (Hazan & Shaver, 1987; Uchino, 2014), and weight remained a proxy for health and a measure of risk of heart disease. Couples' interconnectedness was physical and emotional, and they negotiated considerable complexity in the context of sometimes conflicting norms of relationships and health. Meeting the demands of both was imperative, signalled by the work couples did to maintain recognisable or viable identities as partners and health citizens (Butler, 1993; Davies, 2013). Failures to engage in appropriate health behaviours were constructed as problematic for the relationship as well as for a partner's health (Crawford, 2006). There were conflicts between and within health and relationship norms, such as the

challenges posed by expectations of interdependency which could come into conflict with neoliberal values of autonomy in health and coupledness. Participants adopted normative health and relationship practices, but they also occasionally deterritorialised them, taking lines of flight that disrupted dominant discourses of health and intimate relationships.

7.1 ‘In it together’: Affirmative Accounts of Lifestyle Change.

In the intermingling of health and relationships, not only are positive relationships constructed as productive of desired health outcomes, but good health practices are also indicative of a positive relationship (e.g. Robles, 2014), and participants evaluated their health practices as well as their relationships in line with these ideals. Participants oriented to relationship norms of compatibility, similarity and harmony, and worked to enact these norms through their health-related practices (Braybrook et al., 2014; hooks, 2000; Rose, 1999; Watts & Stenner, 2010). Graham and Holly (early 50s, retired public service workers) established the dynamic interconnectedness of their health and relationship as they talked about managing Holly’s diagnosis with CHD and the ill health that Graham had also experienced:

Holly: you just get on with it you don’t (.) you don’t give into it but you don’t aggravate it ((laughter)) you just go with the flow you do what you can (..) and it’s the same with you isn’t it

Graham: I think what’s she’s saying is we’re both we’ve both been very ill and erm (..) we discuss everything fully between us there’s no erm (..) there’s nothing to do with hers that’s nothing to do with me or mine’s got nothing to do with her because we’re in it together so (...) (Int.1.,ll.14-22)

Holly talked about managing her illness in terms of balance and acceptance. She constructed her management of her condition as dynamic as she regulated the tension between giving in to and aggravating her symptoms. Graham picked up the language of symmetry and harmony when he talked about the completeness and equity of their concern for and involvement in each other’s health, constructing their health-related practices as interdependent and comprehensive, with reiterations of ‘nothing’ (that is not shared), and the statement that ‘we discuss everything fully between us’, warranted by the overarching partnership of their being ‘in it together’. This talk reflected current understandings of romantic relationships as equal and

characterised by open communication (Loving & Slatcher, 2013), and established their relationship as a site of mutual concern for each other's health (Holt-Lunsted, 2010).

From a Deleuzian perspective, Graham can be seen as locating himself and Holly within each other's assemblages of health, a physical and emotional interconnectedness. Rather than their concern for each other's health being grounded in an essential self that is programmed by evolution to invest in a partner's well-being (Pietromonaco, Uchino, & Schetter, 2013), the concept of distinct but overlapping assemblages of health and of intimate relationships accounts for a mutual affecting and being affected which arises out of physical as well as emotional proximity. Whatever a partner's health concerns, practices, level of concern, or relationship quality, engagement or lack of engagement (MacLean et al., 2014), couples still inevitably affected and were affected by their partner, exemplified in the extract below.

In the couples' accounts, there was a blurring of boundaries between each partners' physical and psychological experiences of illness and recovery. Mutuality and interconnectedness were thus constructed in the sharing of embodied experiences, as when Henry reflected on the impact of his illness on Catherine:

Henry: well I think it did affect Catherine quite a bit a I think that side of it even more than myself you know uh I just took it once I'd got myself sorted and took it for granted and uh Catherine was she's getting back over it now I think

Catherine: it took about uh a good week to get over it and to feel better (Int.1,11392-395)

Henry and Catherine discussed her recovery from his illness in a way that took for granted a shared embodiment. It was common for the participants who had received a diagnosis of CHD to claim that the experience had been equally, if not more, difficult for the partner than for themselves. This acknowledgement of their being jointly affected by the event took for granted an interconnection that is physical as well as emotional, blurring the boundaries between carer and cared for. The shared burden of illness produced a balance in their mutual support and coping,

allowed Henry to claim a quicker recovery, and afforded a recognition of the impact on Catherine and consequently, space for her recovery.

Constructions of intimate relationships and health as interdependent and mutually supportive are also illustrated in the extract below where Ellen reflected on Paul's successful recovery which they attributed to their partnership and good teamwork:

Ellen: it it does you good to appreciate (..) I will still keep saying if anyone is on their own and they've got nobody to motivate them (.) it must be terribly difficult (....) (Int.3.ll.1285-1287)

Evoking the difficulties faced by someone managing CHD and lifestyle change alone, Ellen positioned romantic partners as instrumental in supporting and promoting each other's health. Her focus on motivation suggested that a partner may provide a reason to maintain health. The partner's essential role as a motivator also legitimised practices related to encouraging partners to engage in lifestyle change. Ellen constructed this interdependence as positive, in her extreme designation of singleness as '*terribly difficult*', establishing a dichotomy between coupledness where health is sustained through partner support and a single life of difficulty and deficit. She reinforced the normativity of intimate relationships through negative constructions of the world that lies outside the health-promoting security of coupledness (Finn, 2010). But Paul responded by reflecting on their good teamwork and connectedness with more ambivalence:

Paul: yeah I think that's (.) I don't know whether that's a good thing or a bad thing really

Ellen: ha ha ha

Int: what do you mean

Paul: because (.) erm (..) when one not if when one of us goes the other one's going to be quite lonely (Int.3.ll.1298-1306)

Paul troubled Ellen's positive construction of their interdependence in his contemplation of a future '*when not if*' one of them will be alone. His prediction of loneliness still reinforced discourses of romantic partners as essential to each other's wellbeing, however, and the polarised binaries of singleness and coupledness,

loneliness and health upon which he and Ellen drew excluded an affirmative vision of wellbeing outside intimate relationships.

Health and relationships also affect each other in ways that were constructed as affirmative. For example, when health practices were in harmony, illness could become an opportunity for relationship growth and flourishing (Frank, 1995; Radley, 1988). Susan built such an account in describing how the lifestyle change necessitated by George's diagnosis with CHD had a positive effect on their relationship, as well as upon his health:

Susan: it seems a strange thing to say but it's been a blessing and it's not been in disguise (Int.1.11.310-311)

Susan acknowledges dominant understandings of illness as indicative of disorder and dysfunction in her signalling of her positive evaluation as '*strange*'. But in line with Frank (1995) and Calhoun and Tedeschi's (2014) recognition of illness and trauma as opportunities for growth and restitution, Susan emphatically constructed his illness as positive for both his health and their relationship, since his previous behaviour had threatened not only his health, but also violated expectations that a good relationship should be a site of good health practices:

Susan: yeah ((laughter)) but it's changed him so much (.) instead of having to go outside all the time for a cigarette (.) erm and (.) I think I didn't feel deeply resentful about it but it was an anxiety for me and there are (.) little resentments there about it thinking oh god he's going outside for another cigarette and (.) erm (Int.1.p.231)

George's previous lifestyle, in particular his smoking, was a source of '*anxiety*' but also '*resentment*' for Susan. The event of George's diagnosis instigated lifestyle changes which eliminated the threat to his health as well the negative emotions they evoked in his partner. Susan minimised this negativity with her modifying of her resentment as '*little*' and not '*deeply resentful*', but her frustration was signalled by her exclamation '*oh god*' and the frequency implied by '*another cigarette*'. Davies (2013) argues that anger is associated with the self or another's failure to conform to norms, such as the relationship and health ideals that George violated in his smoking. Admitting that his smoking made her angry and afraid was done very tentatively by Susan, signalling that these emotions in turn trouble

normative notions of what a happy couple can say, think and feel, and indicating the complex dynamics that couples negotiate in their health practices.

Both health and romantic relationships can be thought of as ‘happy objects’, offering the promise of happiness and fulfilment (Ahmed, 2010). But the ways in which couples can be happy conform to wider social discourses of romantic love and appropriate coupledness (Finn, 2010). The overlap between health and intimate relationships is a site of governmentality, where couples regulate each other’s health; a good relationship is one that promotes health. Susan oriented to these discourses when she attributed her happiness to the harmony between their health and relationship behaviours since George’s diagnosis:

Susan: but you know the biggest and biggest bonus is giving up smoking because I’ve carried that fear and now it’s happened and there’s been this wonderful outcome so I feel great you know because he’s given up the smoking and he’s had the heart attack (Int.1.II.1548-1552)

Her fears were realised, but they both coped, and the heart attack functioned as a lever to remove the smoking that troubled their identity as a healthy and happy couple. Susan expresses her emotions in the extreme evocations the ‘*biggest bonus*’, ‘*wonderful*’ and ‘*great*’ that signal her relief from anxiety and deep happiness. Davies (2013) argues that processes of normalisation produce emotions such as those expressed by Susan, including ‘longing’ for recognition of oneself as a ‘viable being’; ‘passionate attachment’ signalling an investment in one’s identification with certain norms, and joy in being recognised as fulfilling such demands (p.24). George’s smoking threatened their functioning as a couple as well as his health, and with his change in behaviour, they can fulfil ideals of good health citizenship and romantic relationships. Positive health practices that are in alignment with relationship norms can produce happiness such as Susan’s above. But not only are there sometimes conflicts between understandings of appropriate health and coupledness, but contradictions within each discourse have implications for health and relationships.

7.2 Competing Norms of Health and Intimate Relationships.

The boundaries of relationship ideals and imperatives of health were revealed by participants' distress or discomfort when they were breached. Couples constructed relationships as a site of health work in what they did, and how they accounted for what they did not do. Relationship science idealises open, non-emotive communication which respects the partner's agency and autonomy, and pathologises conflict (Gottman & Notarius, 2000; Loving & Schlater, 2013; Robles et al., 2014). This construction is also drawn on by my participants in Study 2. In the earlier extract, for example, Susan negotiated her anxiety about George's smoking in the context of understandings of personal responsibility for health and respect for autonomy and individuality within romantic relationships. She thinks, but does not say '*oh god he's going outside for another cigarette*'. In the following extract, May oriented to exercise as something that couples should do together in the way that she talked, in all three interviews, about why she did not attend cardiac rehabilitation classes with Tom:

May: *my confession time I haven't been for the last weeks*

Tom: *or more*

May: *at all*

Tom: *for three*

May: *no I think it's two weeks*

Tom: *since the beginning of the month about two weeks*

Int: *is it the weather or is it just that things are getting a busy or*

May: *it's just there's so much to do and I just thought I can't do it I can't do everything [you know and when that has gone but I I intend*

Tom: *[all the things all the things to do no she does a lot I mean she's not just*

May: *to start again after Christmas it's not that oh I can't be bothered it's er it's just there's been so much on (Int2.171-187)*

May's use of '*confession*' established a moral framework for couples' engagement in each other's health, and signalled a transgressive position for her in

relation to her participation in their exercise regime. Her non-engagement was problematized by her need to account for it, but she also asserted competing demands on her time. Caring for Tom was not the only demand on her time, and her extreme case formulation ‘*I just thought I can’t do it I can’t do everything*’ conveyed an impossibility of managing all her responsibilities, and defended her against potential claims of lack of commitment or effort (Pomerantz & Heritage, 2012). Tom supported her case by confirming how busy May was, but his defence left unchallenged the normative assumption that, outside of May’s exceptional case, partners should support each other in their lifestyle practices. Not doing so remained dispreferred, a potential source of guilt and blame, signalled by Tom’s disavowal of a lack of concern on May’s part, that constructed being ‘*bothered*’, involved, and sharing as normative in romantic relationships. Partners who balance multiple roles, such as careers, homemaking, and parenting, also negotiate expectations of their responsibilities for a partner’s health, with clear potential for conflicting norms of autonomy and interdependence within intimate relationships.

The participants in Study 2 constructed coupledness as contributing to each other’s health, which conformed to relationship theories that assume romantic love to be synonymous and in alignment with care for partners’ health. But some interactions indicated that the practices arising from good health citizenship might transgress relationship norms and expectations of support and affection. In an extract from their first interview, Eddie and Lily (mid 60s, retired public service workers) discussed a trip to a concert that they had planned before Eddie’s illness, and competing needs for emotional support and encouragement to follow health injunctions, an issue they returned to in the extract from their second interview:

Lily: *because I’m going ((laughter)) whether I go on my own or whether I go with Eddie I’m obviously I’d like Eddie to come but I’m hoping the fact that I’m going anyway will spur him on and get [him*

Eddie: *[you see I’ve had absolutely no sympathy whatsoever throughout the whole thing ((Laughter)) you know if you can’t even get a bit of sympathy after a heart attack then I stand no chance do I really*

Lily: *you got sympathy it’s just [not in the guise that you think it should be*

- Eddie: *[it's tough tough love I think yeah
yeah I know well that's not what you need (.) every now and
again you need a little bit of that when you're feeling crap*
- Lily: *well I've done that when you've needed it*
- Eddie: *I know you have (.) I've sung your praises the whole time (.)
that's no criticism*
- Lily: *and when you've needed to sit down and shut up I've told you so*
- Eddie: *I know (.) I know (.) it was an attempt at humour (.) yes I realise
that you know that don't understand humour but ((laughter))
(Int.1.ll.554-581)*
- Eddie: *it's a pretty scary sort of experience to to go through really but
(.) you know everybody round me has been very positive and
you know having a good [northern] wife there's there's no
there's no sympathy off you now ((laughter))*
- Int: *I remember you mentioning that last time the that you were kind
of*
- Eddie: *no she's (..) she's probably the the sort of nurse that you need
but not necessarily the sort of nurse that you want ((laughter))
(.) but*
- Lily: *it's the sort of nurse that you're stuck with (Int.2.ll.481-494)*

Lily's position as carer legitimised practices such as encouraging Eddie's return to his pre-illness level of functioning, while he positioned himself as not-yet-recovered and still in need of sympathy, a need which Lily's 'tough love' did not fully meet. For Lily, relationship practices of affection and reassurance were subordinate to imperatives of health. Both partners acknowledged each other's position without conceding their own convictions or needs. Eddie recognised the efficacy of Lily's approach in supporting his recovery, conceding that sympathy is 'not what you need', but reasserted that illness also involved a need for comfort and sympathy, 'a little bit of that when you're feeling crap'. Lily oriented to relationship norms of empathic caring in her defence 'I've done that when you've needed it', indicating that she regulated her caring practices in accordance with his needs and best interests. Lily's defence signalled that Eddie had implied a deficit in her health and relationship practices, and he repaired his criticism by expressing gratitude for

his care. Lily then extended her defence as she reiterated her willingness to transgress relationship norms to meet his health needs.

Eddie used laughter and humour to allow him to both express and retreat from the troubling gap between the sympathy he desired and Lily's conviction that downplaying his anxieties would aid his recovery. Massumi (2003) considers the affects and affordances of humour: 'whether a person is going to joke or get angry when they are in a tight spot that uncertainty produces an affective change in the situation... it affects where people might go or what they might do as a result' (p.119). Here, Eddie worked to defuse any harshness towards Lily, and minimise this gap between their respective positions and behaviours, indicating the normativity of harmonious relationship and health practices within intimate relationships.

Just as relationship norms can disrupt caring and health management, health practices also have the potential to trouble relationship norms and identities. In the extract below, Ellen and Paul indicated the potential for tension in the giving and receiving of support and care in periods of ill-health as they discuss Paul's adherence to his post-surgery exercises:

Ellen: Paul did them religiously but I'd been talking to some ladies and their husbands in the same situation and they think it's great 'cause they're being looked after and (.) they're they're really lapped it up but Paul isn't that way

Paul: I hated it

Ellen: he'd been a brilliant patient really (.) I mean he will say (.) oh I'll do that (.) I mean he gets a bit grumpy with me sometimes but I'm only trying to help but then we know we know (.) we don't get just because (laughter) but we you know (.) erm (.) 'cause sometimes you are tired

Paul: don't mollycoddle that's what I said

Ellen: that's the word, that's the word don't mollycoddle me and I said alright alright right right (Int.2.ll.632-652)

As with May's 'confession', the use of 'religiously' here indicates a moral dimension to expectations of partners' health behaviour, and establishes norms of appropriate coupledness. The caring responsibilities couples undertake leave them open to the risk of imbalance in their contribution to the relationship that contravenes

relationship ideals of equality (Dryden, 1998). Ellen identified a degree of exploitation in other women's accounts of caring in her pejorative evaluation of other husbands who had '*really lapped it up*'. She contrasts this over-enjoyment of being cared for with Paul's embodiment of a '*brilliant patient*', in his rejection of a passive or over-demanding illness identity. Ellen draws on neoliberal notions of agency and independence in relation to both health (Rose, 2001) and intimate relationships (Loving & Schlater, 2013). Paul's grumpiness could be construed as negative, indicating conflict or ingratitude, but Ellen accounts for his bad temper as a sign of his independence and laudable dislike of '*mollycoddling*' if her support crosses a boundary of over-protectiveness or infantilisation of him. The tiredness which also excuses him is also a sign of his independence, as his being a good patient and partner is also constructed through his willingness to share their household labour, acknowledged by Ellen's citing of his offers to help in '*I'll do that*'. Ellen and Paul thus delineated the contours of appropriate joint practices, and indicated the ways in which health behaviours can impinge on relationship norms.

The ways in which relationship norms such as equality and independence (Holmberg & MacKenzie, 2002) can be threatened by joint endeavour and responsibility for health are negotiated in dynamic ways, as Holly's account of the ramifications of couples' co-management of health for both patient and partner after her diagnosis with CHD indicates:

Holly: you know he worries too much he worries if there's nobody with me he worries he won't leave me on my own so it restricts Graham you know he can't go off and do his photography you know he can't have a day to himself and yes it it gets on my nerves as much as it does yours because I like a day to myself and (.) sort of you're planning on getting somebody in to look after me I don't want anything I've got two cats and I think I'll phone the doctor and I'll be alright (Int.1.ll.1118-1126)

Throughout the interview, Graham had positioned himself as responsible for Holly's health, diet and activity levels since her diagnosis with CHD, creating a dependent subject position for Holly. She oriented to the implication that she was a source of anxiety and restriction for Graham in her rejection of this dispreferred position by attributing his concern to over-worrying on his part rather than to her level of need. She further resisted this identity by turning the tables and

problematizing the effects of his responsibilities upon his well-being, repositioning herself from being cared for by Graham to caring for him, sharing his practices and subjectivities of monitoring and anxiety. Graham's caring and health-managing practices also gave rise to mutual feelings of frustration and irritation. Holly acknowledged the restrictions her health problems placed upon Graham, asserting that that they both needed independence and time to themselves as well as togetherness. Holly resisted being positioned as helpless and dependent, and emphasised her agency, independence, and capacity to take care of herself, '*I don't want anything I've got two cats*', and her ability to phone for help. Agency and autonomy lie at the heart of neoliberal health messages, but also are salient in discourses of intimate relationships (Giddens, 1992). Holly oriented to these values in her construction of intimate relationships as requiring a level of independence and self-sufficiency which can conflict with norms of caring and joint engagement in health.

Support and acceptance are also normative in long-term relationships, and tensions can arise between practices related to support and imperatives of health. In the extracts below, Dan's understandings of Louise's needs in relation to her CHD came into conflict with her own coping strategies. These tensions took material form when Dan bought Louise a medical alert bracelet. In the extract below, Dan offered his rationale for wanting Louise to wear the bracelet:

Dan: that's support and important acceptance of the fact that you've had a problem and and er (.) it's something that people need to know about in case er (.) you know you have another problem (Int.3.ll.570-573)

For Dan, the bracelet functioned to indicate the severity of her condition to Louise to ensure she modified her health behaviours, and to alert other people to the risk of recurrence. Here, Dan shared his own understanding of the bracelet as a form of support and as instrumental in Louise's psychological recovery, the '*important acceptance*' of her problematic health. Throughout the interviews, Dan took an expert position in relation to the pharmacology and psychology of CHD, and advocated medical information and understanding as a solution to Louise's anxiety. But here he also demonstrated his own fears for Louise's health in his voicing of the

possibility of ‘*another problem*’, while Louise negotiated the conflicted meanings of the bracelet.

Louise: yeah this bracelet I mean it's really nice my husband let me pick it out I picked out exactly the one I wanted and everything and every now and then I look down and I and I say see your husband's love see your husband's love see your husband's love because (..) it has that little (.) sign on it that means there's something wrong with you you are different you know one of these things doesn't belong like on Sesame Street (Int.2.II.621-627)

Louise instructed herself to see the bracelet as an expression of Dan's love in her mantra-like, three-part repetition of ‘*see your husband's love*’ that indicated the effort this perspective required, with the extract as a whole illustrating a troubling dissonance between behaviours that are romantically appropriate but which categorise Louise as ill and risky. Carla Willig writes of the ways in which subjects are ‘captured’ in a ‘spoilt identity’ by illness discourses when they experience ill-health in a health-valuing society (Willig, 2011, p.900). Louise signalled such a capture when she states that the bracelet marked her out as ‘*wrong*’ ‘*different*’ and ‘*doesn't belong*’. The bracelet materialises the tensions inherent in Dan's care and concern for her, which may have been appropriate in the context of their relationship and her illness, but which nonetheless had negative ramifications and positioned her in an undesired health identity. Dan's emphasis on her illness was at odds with her desire to minimise and move on from the experience of CHD in order to restore a sense of wellness and confidence in her body, and in this sense, he violated relationship norms of support.

Louise attempted to resolve these conflicts by buying another bracelet which she wore to disguise or limit the impact of the medical alert one, with only partial success:

Louise: I've gotten a couple little er a couple little charms to go on it because when you wear them together and you flip it over you can still see that it's a medical alert but it's not quite so (..) obvious and I just I hate (..) just (.) it's like wearing a tattoo on your forehead (.) hello I had a heart attack I'm dangerous and because erm (...) it it has affected some of my you know my

friends look at me I feel (.) you know is she going to be okay
(Int.3.ll.590-600)

In this third interview, Louise's affective response to the bracelet is unchanged. As someone who has had a heart attack and now wears a medical alert, Louise designated herself as '*dangerous*', describing in an emotionally powerful way how her friends responded to her health-riskiness. Louise's affective response can be made sense of both in terms of norms (Davies, 2013) and the way illnesses like CHD are linked to risk and stigma (Willig, 2011). Bronwyn Davies (2013) associates fear and anxiety with the experience or anticipation of 'destabilisation' (p.24), of not belonging within secure, viable or valued categories. Equally, anger and disgust may also be experienced by and towards those who do not conform to or are made intelligible by norms. Carla Willig (2011) for example, writes that contemporary discourses that construct ill-health as deficit and dysfunction, and attributions of individual responsibility for lifestyle diseases such as CHD and cancer may contribute to such alienation and stigmatisation.

Despite its status as a common, treatable, chronic condition affecting an older population, CHD is also associated with the language of fear and risk in health information and promotion (Porroche-Escudero, 2014), and it is this discourse that Louise drew on in her problematisation of the bracelet as a visible sign of her '*dangerous*' condition. Louise's illness moved her into an undesired subject position; she could no longer be intelligible to Dan and her friends within health norms (e.g. not having to wear an alert). The bracelet – potentially a sign of Dan's love that complied with relationship norms of care, instead represented Dan's positioning of her illness, and therefore herself, as risky, facilitating the process of destabilisation. Since partners are not expected to undermine their loved one (Cole et al., 2013; MacLean et al., 2014), the bracelet, as a mark of destabilisation, was incompatible with relationship norms of acceptance and support. Normative caring and support expectations of romantic relationships are thus troubled in complex ways within the context of ill health, so that Dan's act of love ('*see your husband's love*') failed to meet Louise's needs in a materialisation of tensions between norms of care, health, and intimate relationships.

Participants' expectations of compatibility and harmony in health practices were also signalled by the 'work' they did to account for difference and dissonance. In the extract below, Catherine took for granted a shared, embodied experience of managing their new diet:

Catherine: so it's a different way of (.) er food intake now for us er (...) I don't whether it works for me or not yet I've got to see what I can do about it (...) mhm

*Henry: you don't have to eat same as me anyway do you
(Int.1.ll.1063-1066)*

Throughout the interviews, Catherine frequently expressed concern about the volume of food that Henry ate and her desire for him to eat less, and she implied that Henry's diet should match hers in order to be healthier, while Henry resisted being positioned as eating too much. In this extract, Henry challenged the need for this level of shared practice and was prepared to transgress the relationship norm of shared eating habits to maintain his dietary independence. When Henry defended his intake as appropriate, and refused to concede to her assertion that his portions were too large, Catherine worked to account for this lack of compatibility and congruence in their eating:

Catherine: I think personally I mean women especially small slim women (.) they can't eat all that stuff really (.) you know it's just too much you know you just can't eat it whereas a man your size you would eat more [mmm] mmm (Int.2.ll.683-696)

Catherine generalised the debate and distanced it from their personal situation with references to '*small slim women*' and '*a man your size*'. She attributed the troubling dissonance between their diets and intake to gender rather than personal qualities. With this attribution, Catherine did not have to change her assessment of his portion size as unreasonable, indicated by her extreme case formulation and three-part list that constructed the impossibility of her trying to match her eating to his, and can retain her approval of '*small slim women*', like herself. But by attributing their irreconcilable difference to biological and not behavioural causes, she avoided blaming Henry for not demonstrating appropriate responsibility for his health or for resisting her influence attempts.

Susan and George also negotiated different identities, practices, and values connected with diet and lifestyle. Susan attributed her knowledge of food to her experience of cancer. She constructed food as protective and curative, and drew on contemporary discourses of healthy living as productive of holistic wellbeing (Crawford, 2006). George distanced himself from any such expert knowledge about diet, but they both managed their dissonant approaches to construct an acceptable health identity for George:

George: yeah I'm afraid if I was on my own

Susan: he doesn't care

George: I would probably ride entirely over the top you know (.) a child of 1950s when you (..) there were no health concerns connected with food except how you got hold of it really and erm you know rationing was off and hey er (.) you you

Susan: but food was less adulterated then

*George: we ate very healthily at the same time in the sense that (.) it was all garden grown vegetables erm (.) that we lived on
(Int.1.ll.125-138)*

Susan's assertion that '*he doesn't care*' about diet, is countered by George, as he defended himself against possible charge of irresponsibility in relation to health. He legitimised his attitude as appropriate to the austerity of his childhood, where rationing precluded being fussy or particular and scarcity necessitated the ability to eat when and what you could. Susan softened her critique and offers a more positive health identity in her claim that food was healthier in the past. She inferred that less vigilance was required then, as food was purer in contrast to the label-reading and information-seeking that she had previously claimed was necessary now. George concurred, and made claims to a diet that conformed to Susan's ideals of natural and healthy food. They negotiated an acceptable health identity for them both, by not undermining Susan's consuming concern with diet and lifestyle, and by offering mitigating account of George's eating. They resolved their differences in a shared understanding of what constitutes a healthy diet, one which harked back to a simpler, healthier past— the diet George had in his youth.

While couples worked to negotiate congruent and viable health and relationship identities, adopting as well as resisting each other's and wider social understandings of healthy lifestyle, they occasionally took lines of flight that subverted dominant discourses, and asserted alternative values. Using Deleuze's concepts of affect and assemblage, I mapped some of these deterritorialisations in couples' accounts of lifestyle management.

7.3 Changing Norms: Transformation and Lines of Flight.

In the participants' talk, there were examples of their transformation of fearful and anxious understandings and affects into something bearable and liveable. These transformations afforded access to new and more affirmative ways of living in the flux and uncertainty of both health and human relationships. Davies (2013) suggests that positive emotions arise from conforming to norms, she argues that affirmative affects can also be produced through 'changing the norms through which we are recognised' (p.24). For example, below Holly described a learning process that took place between partners:

Graham: we we have the same neither of us do depression really we're quite

Holly: no we don't we don't do that

Graham: pragmatic about living that way you know you if there's a problem it's how you going to sort it out rather than you know

Holly: well I think the the yeah that's thanks to you because I used to be the most depressed person in the world probably or in the country but Graham has made me see that things can be sorted out and why do you sit there worrying about them when talking about them sorting them out and putting them right is a problem finished (.) and you've helped me a lot with that because before I was I had depression for England I think (.) I was I was very (.) tearful and I'd worry about everything I'd worry about nothing and I don't

Graham: it's point pointless activity worrying about this (Int.1.ll.1355-1376)

At the beginning of the extract, Graham and Holly co-construction of health extended to mental health and negative emotions. Their account of agency and practical action as an antidote to depression drew on neoliberal discourses of self-

reliance, self-improvement and responsibility for mental as well as physical health (Rose, 1999). But the pragmatic actions that Holly enumerated, '*sorting them out*' '*putting them right*', were achieved through relational rather than individualistic processes, a repeated motif in her statements: '*we don't do that*' '*Graham made me see*', '*talking about them*', and '*you've helped me a lot*'. The emotional costs of health anxiety were invoked by Holly as she recalled previous extreme, negative emotions that resulted from her anxiety '*I used to be the most depressed person in the world*'. But for Holly and Graham, freedom from worry was not entirely enabled by practical problem-solving, rather it came from resisting healthism's cycle of anxiety and control and 'pedagogy of danger' (Crawford, 2006). Control and agency form the cornerstones of neoliberalism and healthism, but Graham's designation of worry as '*pointless*' hints at a form of fatalism, which is nonetheless affirmative in their acceptance of and coping with illness.

Lily and Eddie reproduced similar perspectives in the extract below, where their acknowledgement of a lack of control formed the basis for their acceptance of Eddie's illness and their hopes for the future:

Lily: no I'm glad really we have lived like that we have always tried to make the best of everyday if we've wanted to do something we've done it because we've always said well from experience you never know what's round the corner you never know what's going to happen the phone rings and your whole life changes so we've always been a bit hedonistic really and I'm glad now you know our philosophy is you know we've been it's been right we've lived the right way

Eddie: yes even if I hadn't have made it we did a lot of stuff and hopefully we'll still do a lot more stuff you know

Lily: yeah we'll just pick up where we left off

Eddie: well we will I mean the prognosis is very good and as long as I am sensible about it I might even be better than I was before

Lily: you should be your heart should be better than it was before (Int.1.ll.1047-1067)

Lily's account of health here was one of uncertainty and chance, an acknowledgement of powerlessness which legitimised their '*hedonistic*' approach as the '*right way*' to live. It might seem counter-intuitive that such uncertainty gives

rise to hope, but Massumi (2002) argues that ‘uncertainty produces an affective change’ (p.109), a recognition of complexity and ambiguity that is empowering, because it provides ‘a margin of manoeuvrability...a feeling that there is always an opening to experiment, to try and see’ (p.106). Massumi (2002) thus equates affect with hope, reminding us openness is important, and as we negotiate that openness, with greater connectedness ‘comes a stronger sense of embeddedness in a larger field of life – a heightened sense of belonging, with other people and to other places’ (p.107). Lily and Eddie were able to contemplate with equanimity the possibility that Eddie could have died, and connect to an affirmative future.

Even for couples who did not anticipate increases in capacities, acceptance of the ageing process could still be affirmative. Below, for example it enabled Henry to reconcile his and Catherine’s different levels of acceptance of the ageing process:

Henry: you know I don’t feel my age so [mmm] you know that’s the main thing er Catherine worries or doesn’t like growing old (.) it doesn’t enter my head really you know um I don’t think about it at all [mmm] so

Catherine: well I don’t I don’t worry about it [well] I just don’t like it because I can’t do things that I used to do

Henry: yeah but you know you’ve just got to accept it and plod on and you know do what you can do can’t you

Catherine: yeah mmm

Henry: well there’s lots of things that I can’t do now that I used to do but it don’t bother me you know (.) if you can’t do them you can’t do them but er (Int.3.ll.1188-1204)

Henry rejected the logic of neoliberal health messages which value and normalise perfect physical and mental functioning, whereby inevitable change renders old age abject. He resisted categorisation and stigmatisation based on his age, asserting an embodied and independent experience in his claim not to ‘*feel*’ his age. He constructs his freedom from concern as complete, not something he works at, in his claims that ‘*it doesn’t enter my head*’ and ‘*I don’t think about it at all*’. Catherine justified her position by a claim to a rational cause for her unhappiness with the ageing process in the reduction in her physical capacities. Henry’s response calls on acceptance rather than agency, and a persistence in being that rises above

physical limitations. A Deleuzian/Spinozan conceptualisation of health as the capacities to form connections, to affect and be affected is not limited to physical functioning (Duff, 2014), and Henry drew on this understanding in his construction of physical capacities as incidental rather than central to health. He transformed discourses of ageing as deficit and decline, and broke away from cycles of anxiety and control. He invited Catherine and exerted his own freedom to still '*do what you can do*', and released himself from worry and distress in his assertion that '*it don't bother me*', asserting a level of acceptance that Deleuze suggests offers a life-affirming escape from the impasses of knowledge and power.

7.4 Discussion.

I identified an overarching construction of health as a joint endeavour within which couples managed the experience of illness and lifestyle change. Couples drew on normative discourses of intimate relationships and of health and work on themselves and each other to achieve ideals of both. Foucault's technologies of the self (1988) become joint technologies, with the goal of achieving both optimal health and a happy relationship. Health practices are performative of responsible health citizenship, but also of appropriate coupledness. Within long-term relationships, happiness and health are understood as indicative of personal responsibility, appropriate 'personhood', and a good relationship. Participants negotiated sometimes competing and conflicting imperatives of health and relationships in different ways. Participants conformed to dominant understandings of healthy lifestyle, and accepted direction and influence from their partners in ways that also preserved relationship ideals of compatibility, support, and harmony.

Incompatibilities or resistance to or a partner's health influence attempts required 'work' to maintain positive relationship and health identities. Relationship norms were sometimes transgressed to achieve health goals, and the reverse also occurred. In this study, joint health practices are constructed as legitimate within long-term relationships, but clearly have the potential to violate other important relationship norms of support and acceptance. Understandings derived from wider social discourses of health, with their emphasis on personal responsibility,

individualism and rational actions based on knowledge and information thus may come into conflict with relationship norms and expectations.

This analysis is in line findings in mainstream health psychology literature that couples are intimately involved in each other's health (Holt-Lunstad et al., 2010; Pietromonaco et al., 2013; Robles et al., 2014), and of wide variability in the nature and efficacy of joint engagement in health (Franks et al., 2006; Goldsmith et al., 2006; Tucker & Anders, 2001). In this literature, negative health interactions are indicative of dysfunctional relationships (Kiecolt-Glaser & Newton, 2001), but I argue that rather than relationships being categorically positive or negative, ideals and imperatives of health are not always being in alignment, and consequently, partners can both support and undermine each other's attempts at lifestyle change in their adherence to imperatives of either health or relationships (Köhler et al., 2016; MacLean et al., 2014).

Robles et al. (2014) acknowledge that couples' investment in each other's health creates the potential for affirmative and negative outcomes, and Joseph et al. (2015) propose that the quality of couples' interactions rather than global categories of relationship quality are better indicators of health outcomes, but this thesis' critical perspective advances these observations by providing a framework for conceptualising how norms of health and relationships are enfolded into couples' health practices (Crawford, 1980, 2006; Rose, 1999, 2001), and for mapping the ensuing power relations that circulate between partners as well as between health institutions and individuals. In the context of intense societal focus on health, people judge and define themselves and others according to how successfully they embody ideals of health and health behaviour (Crawford, 2006). This analysis develops Crawford's ideas by demonstrating that couples evaluated not just themselves and their partners, but also their relationship in terms of their ability to sustain healthy practices.

One aim of this study, stated in Research Question 2, was to develop an analysis of peoples' engagement and non-engagement in lifestyle change that accounted for the dynamism and complexity of health-related behaviours, in a way that is not reductionist or judgmental, and that avoids the logic of blame and guilt.

Deleuze's philosophy conceptualises health as a complex, multiple, dynamic assemblage rather than a stable state which can be achieved and maintained through simple, rational lifestyle decisions and choices (Duff, 2014). Intimate relationships can be thought of as assemblages, and the complex flows between them and assemblages of health form the conditions of possibility for both harmony and conflict. Assemblages of health and intimate relationships can produce harmonious connections for couples, increasing relations and capacities to act, in Deleuzian terms, but these results also demonstrate the ways that competing and conflicting imperatives of health and intimate relationships may diminish powers and capacities in both or either realm, accounting on an ontological level for the varieties of ways in which couple health interactions may contribute affirmatively or negatively to health outcomes.

In contrast to the apparent simplicity and neutrality of individualistic lifestyle advice (Lupton, 2014), the complexities that couples must negotiate in their joint management of lifestyle are considerable. Couples are not simply following clear, achievable lifestyle goals following their partners' diagnosis with CHD, but, as argued in chapter 2, are also negotiating normative ways of understanding themselves as responsible health citizens and good romantic partners. Neoliberal health discourses emphasise risk, and advocate the regulation of diet, exercise, weight, alcohol consumption, and smoking in order to minimise health risks. CHD's status as a lifestyle disease makes these discourses particularly salient for the participants in Study 2, who were also taking part in cardiac rehabilitation classes and managing some recommendations for lifestyle change. In the following chapter, I explore how couples negotiate pervasive discourses of lifestyle as a risk to be managed.

Chapter 8: Expert Patients, Expert Partners

Introduction.

In the previous chapter, I explored couples' construction of healthy lifestyle as a joint endeavour in the context of a partner's diagnosis with CHD. Participants understood intimate relationships as sites of health practices, and appropriate health practices as indicative of a good relationship. Couples engaged in joint technologies of the self, such that, by doing health, they were also doing being a couple, but norms of intimate relationships and of health behaviour were not always in alignment. Tensions arose between imperatives to fulfil both and manage the conflicts and paradoxes within as well as between normative discourses of health and relationships. The tension was particularly acute since the couples in Study 2 constructed health and healthy lifestyle as risk management, not only in the context of powerful discourses of risk relating to health, but also of their or their partner's recent diagnosis with a lifestyle disease (Beck, 1992; Farrimond et al., 2010; Lupton, 1995). Literature relating to couples' co-management of risk is sparse, however, and in this chapter, I develop my analysis of couples' joint technologies of health by exploring in more depth how couples talk about, negotiate and otherwise manage risk in relation to their health.

Crawford (2006) argues that, 'securing health is now understood as an intricate and demanding project' in response to which, individuals develop and draw on a complex, 'lay epidemiology' which includes 'ideas about the causal pathways of disease...strategies of protection and related commentary on individuals, situations, environments and medical recommendations – elaborate and intricate' (p.403). The findings of Study 1 support Crawford's argument, but Study 2's analysis extends his concept to include couples' co-construction and management of knowledge and risk. The 'lay epidemiologies' participants developed encompassed expert, experiential, embodied, and affective knowledges, but these were not always mutual and harmonious. Couples' epidemiologies set up equally intricate power relations as partners adopted, resisted and transformed each other's ways of knowing in their sometimes conflicting evaluation of risk, with implications for their attempts

to maintain positive health and relationship identities. To make sense of the ways that couples manage risk, I drew on Foucault's conceptualisation of different types of power and knowledge.

Foucault's notion of power, as discussed in chapter 4, is not confined to domination, or even social, disciplinary power. He argued that power relations also operate on an interpersonal level, where they can be 'local and reversible' (Foucault, 1988, n.p.) as partners adopt different knowledges with greater or lesser claims to truth and legitimacy. Power is understood here as, 'the play of power relations and resistances' through which 'human beings constitute a relation to themselves...a complex and fragile thing' (Foucault, 1989, p.789), plural, multiple, and open to desubjectification, to a transformation of the self, and therefore captures the ways in which power can circulate in an intimate relationship

In the context of health and lifestyle disease, these relations can be particularly complex. Regular media reports articulating contradictory messages and highlighting flawed or compromised science further create a context in which expert advice, scientific and medical knowledge may be challenged, a position also supported by current policies relating to patient choice, which blurs traditional boundaries between expert medical and lay knowledge (Hansen & Easthope, 2007). Yet lifestyle advice often presents health practices as simple and easy to maintain, while neoliberal health policy that constructs health as a risk that can be managed involves 'erasure of uncertainty with respect to knowledge about the body' (Gard & Wright, 2001, p. 537). An illusion of mastery over health creates an understanding of illness as "'occasioned' by the self" (Stacey, 1997, p. 175), in diseases such as CHD, type II diabetes, and cancer are attributed to poor lifestyle choices. This creates a complex, multiple and sometimes contradictory set of understandings through which patients and their partners have to make sense of their health and illness, that may lead to a sense of empowerment, but can also produce cynicism and fatigue with health information (Crawford, 2006). In this chapter, I identified patterns in the ways that participants made sense of and negotiated the risks associated with their lifestyle and illness within their construction of healthy lifestyle as a joint endeavour which included: negotiations of positions as expert patients and expert partners; the limits of expert and partner's knowledge to illuminate their experience of illness and risk;

and finally, of the multiple knowledges that couples drew on in their management of risk through lifestyle change.

8.1 Negotiating knowledge and risk.

In the context of widely disseminated, but also limited and uncertain scientific knowledge about lifestyle (Hansen & Easthope, 2007), couples drew on expert but also experiential knowledge of themselves and their partner in their construction and management of lifestyle and risk. Their sense-making disrupted traditional dichotomies of knowledge, and demonstrated more contested and blurred practices and understandings, which had to be negotiated between each other as well as individually, or with health care professionals. In line with the salience in the content of health information and advice, couples constructed food as a major risk to be managed in their accounts of lifestyle change, and oriented to discourses of healthy eating as a moral and even civic duty as well as a rational, responsible choice. Patients and partners took on ‘expert’ positions in relation to these discourses, which warranted practices such as the surveillance and management of their partner’s diet. Partners drew on neoliberal discourses that privilege scientific knowledge, and the authority conferred by use of scientific or psychological language legitimised a level of control which might otherwise have transgressed relationship norms of support and acceptance (Goldsmith et al., 2012; Stenner & Watts, 2005). The outcome was a shifting boundary between caring and control negotiated by couples in their management of risk and lifestyle change. In the extract below, Catherine and Henry have been advised to limit consumption of red meat to twice a week which gave rise to the following exchange about Henry’s fried breakfast:

Catherine: then (.) you know really in in theory you shouldn’t eat any more meat until Sunday because Saturday morning he loves bacon fry up you see

Henry: ah but but I did cut down to one little piece of bacon and uh two eggs and toast instead of fried bread and tomatoes so I mean that’s cut down a lot [really

Catherine: [I think I saw a fried bread but I’m not sure

Henry: (.)oh there might have been (.) but there was a toa I had a slice
of toast uh and the rest of the week I have porridge I have
porridge every morning

Catherine and honey (int.1.11.187-194)

In her appeal to ‘theory’, Catherine positioned herself as an expert in relation to the scientific and medical construction of food as a risk to be managed. Practices such as surveillance and management of what should be eaten and when were legitimized by such knowledge, such as her observation that Henry had used up his allowance of meat on a ‘bacon fry up’. References to fried breakfasts as desirable but risky were common in the data, and here Henry deflected culpability by emphasising the reductions and swaps he made, a strategy that recalls the ‘healthy swaps’ suggested in Change4Life. Catherine had watched him cooking, however, and undermined his position as a responsible health citizen with her observations of his indulgence in ‘risky’ food, such as fried bread. Henry defended himself by balancing the fried bread with the more acceptable option of toast, and ‘porridge every morning’. He reproduced constructions of food as safe or risky, virtuous or blameworthy, which is eaten in patterns of indulgence and restraint to neutralise the harm and moral failing of eating for pleasure.

Although both Henry and Catherine oriented to the fried breakfast as incompatible with a healthy lifestyle, this knowledge had to be negotiated in the context of relationship norms which may be violated by overt control. Catherine’s surveillance and criticism were tentative and oblique, ‘I think...I’m not sure’, and also came after the event; it appeared that she observed him cooking at the time without challenging him. In fulfilling relationship norms of concern for each other’s health, they also enacted a form of Foucault’s disciplinary power, and reinforced intimate relationships as sites of the formation and reproduction of social norms and identities (Finn 2005; Finn & Malson, 2008; Rose, 1999). Even though Henry ate the fried breakfast, his need to defend his eating indicated that he and Catherine shared the same understanding of risky food. Henry’s resistance did not challenge assumptions that such food is incompatible with a healthy lifestyle.

At times, however, couples did not adopt the same knowledge or understandings, and worked to legitimise their own positions and practices, while

negotiating norms of relationship harmony and compliance with imperatives of health. In the following extracts, Eddie and Lily navigated different types of knowledge, and their conflicting understandings of and feelings about Eddie's medication:

Eddie: you read the paper one day and they say everybody should be taking statins and then you read the newspaper the next day and nobody should because they cause so much damage and things so you don't know what to believe

Int: how do you feel when you hear about things like that do you

*Eddie: well I I think that you have to be fairly pragmatic you have to listen (.) to the advice of people who you know hopefully know more than you do you know and I listen to my GP and I've listened to the consultants and (.) at least I've got from 80mgs down to 40 and I hope that perhaps it after a year from the event that I I'll have a cholesterol test and maybe I can get down to 20 you know who knows maybe with diet now that I've got the stent in eventually maybe I'll be able to kick them in the head completely
(Int.2.II.524-542)*

These interviews took place in the context of conflicting media stories about the risks and benefits of statins, cholesterol-lowering medication, and here Eddie negotiated this uncertainty in relation to his cholesterol medication. Eddie articulated a dislike to taking medication and a hope for a medication-free future that is common amongst patients (Lupton & Petersen, 1995; Rosenbaum, 2015). But, there was considerable discursive 'work' involved in Eddie's hope. First, he built an account of untrustworthy and uncertain medical knowledge with the statement '*you don't know what to believe*'. The extremes of '*everybody*' and '*nobody*' supported his claim that advice about statins is polarised and therefore impossible to follow, legitimising his potential non-adherence. And he bolstered his position as a rational, compliant patient through claims to be '*pragmatic*' and someone who listens to his GP. Finally, he described a slow and tentative ('*perhaps*') reduction of medication. Such discursive work indicates that it was problematic for Eddie to challenge scientific and medical discourses, and suggests that his desire to cut down on his

medication also threatened a positive patient identity predicated on conformity and adherence to drug regimens (Rosenbaum, 2015).

Eddie consolidated his position by enumerating practices consistent with being an ‘expert patient’, including his knowledge about his dosages, though here this knowledge was aimed at reducing and eliminating rather than adhering to his medication. He drew on the language of drug addiction to reject of his cholesterol-lowering medication when he expressed a desire ‘*to kick them in the head*’. Other participants also constructed changes to diet and exercise which they considered safe and ‘natural’, and preferable to potentially toxic and risky medication, with particular anxiety being expressed over side effects (Farrimond et al., 2010; Rosenbaum, 2015). In this discourse, medical treatment itself became a risk to be managed, with potential for differences in how intimate partners perceived and managed this risk, as illustrated in the interaction between Eddie and Lily below.

Eddie expressed an understanding that, because of his stent and his dietary changes, he would not need to continue his medication long-term. His implication that he was now ‘*cured*’ was taken up by Lily, who oriented to Eddie’s risk of CHD as ongoing:

Lily: but if you don’t take statins and your cholesterol builds up (.) you could get the the artery could block again

Eddie: yes I realise I mean you just have to take advice on on that

Lily: sorry that’s my concern I think he’s he needs to keep taking them
(Int.2.ll.527-553)

Lily legitimised her counter-position through her ‘expert’ knowledge of a causative chain in which not taking the statin would contribute to a recurrence of symptoms of his CHD. Her if/when argument emphatically constructed his risk as ongoing, and the medication as having a key preventative role, since she feared that without the statins, his cholesterol would build up and an artery would block. He concurred, though weakly. He did not accept her opinion as authoritative, but deferred to a higher, though vague, source of ‘*advice*’. Lily dismissed this higher authority and stated her position more strongly. Her apology signalled that she was transgressing some relationship norms in her opposition to Eddie’s doubts, but she

justified her opposition to his stance in her claim '*that's my concern*', which functioned to both express her anxiety and construct his health as her legitimate business.

As demonstrated in the previous chapter, violations of health and relationship norms required discursive work to maintain positive identities in both realms, and there were also implicit expectations that health practices would be harmonious, exemplified in the way that Lily responded to the troubling lack of convergence of their positions on this point:

Lily: but it's not uncommon

Eddie: I I know

Lily: a lot lots and lots of people I take medication every day

Eddie: I know

Lily: you've just got to

Eddie: I know

Lily: not be precious about it you've just got to accept it as part of your routine

Eddie: yeah yeah (.) (Int.2.II.565-580)

Rather than accept their differences on the issue of medication, Lily used both 'expert' and her own experiential knowledge to support her position and to persuade Eddie to accept the need for his medication. While relationship norms legitimised Lily's concern for his health, her expectations of compliance from Eddie were signalled by her stronger injunctions, '*you've just got to*' and repetition, which indicated a troubling of their relationship when his agreement was not wholeheartedly forthcoming. Lily normalised the taking of medication, universalising compliance with medical advice and knowledge in her use of '*a lot lots and lots*', and appeals to norms of similarity and shared behaviour when she reminded him, '*I take medication every day*'.

Lily's argument constructed rationality and knowledge as the answer to distress or uncertainty. Eddie did not want to keep taking his medication because of its side effects and because he hoped to reach a state of wellness where he would not

need them. Lily's response to his reluctance was to offer the scientific, medical rationale for taking them. To resist this would lay him open to a charge of being 'precious', a criticism that implies an irrational fussiness. Eddie resisted but did not directly contradict the power of rationality and medical knowledge. His repetition of 'I know' was ambiguous, functioning to assert his own equal knowledge whilst still acknowledging the validity of her position, and his final 'yeah yeah' worked as both agreement and dismissal. This ambiguity left unresolved tensions between Eddie and Lily's divergent positions. Considering this talk through a Foucauldian lens, power appears to circulate between the partners in complex ways as they eluded each other's attempts to persuade and control. Each resisted the discourses of risk around illness, medication, and individual responsibility that their partner drew upon. This negotiation of knowledge offers a framework for understanding the patterns of resistance and compliance with partner's health influence attempts seen in mainstream literature (Goldsmith et al., 2006; Murray et al., 2006).

In the context of multiple and contradictory scientific and medical discourses, patients and partners had to negotiate the lifesaving promise of medical technologies that simultaneously held inevitable risks and costs. Below Louise had been expressing considerable distress over symptoms of anxiety that she attributed to an allergen in her medication, while Dan attempted to reassure her of its safety. In so doing they offer a further example of how couples' diverse understandings and knowledges can lead to tensions around control and power in intimate relationships.

Dan: *I've laboured to try to convince her that misoprostol is misprostol that yes they're different er compounds that they put in to to um prepare the medication but but those are non-therapeutic compounds and and it it it's still the same medication whether it has some lac lactose in it or not but it er it's a strain because I'd like to have her go ahead and do it but I'm loathed to um just put my foot down and and and say you know you're going to do this (Int.1.ll.309-316)*

Louise had stated in an earlier part of the interview that greater knowledge about the cause of her condition would restore her sense of control and soothe her distress over suspected side effects of her medication. Dan had researched Louise's medication, and not found evidence to support her link between anxiety the

suspected allergen. Despite his expert pharmacological terminology, he had to ‘*labour to convince her*’, indicating that health information was not smoothly transmitted, but was resisted by Louise in the light of her personal experience. Cognitive models of health beliefs and behaviours suggest that information and education would enable Louise to revise her negative evaluation of the medication, and would reduce her anxiety (Ogden, 2007). But the expert information Dan presented did not calm her fears and the limits of scientific knowledge are evident in its failure to account for affective, embodied experiences.

Dan’s expert position and associated analysis of risk also set particular power relations in motion. The power differential between Dan and Louise’s expert and experiential knowledge became the lens through which partners justify health and relationship behaviours. Dan implied in the possibility that he could ‘*just put my foot down*’ or ‘*say you know you’re going to do this*’, but discarded this option. He was ‘*loathed*’ to engage in a level of control, even coercion, which would potentially violate relationship norms of equality, or responsiveness to the other’s position (Dryden, 1997). Dan’s control attempts through claims to expert knowledge were thus not only ineffective, but also had the potential to violate other interpersonal norms. The gap between his knowledge and the rational response he expected from Louise resulted in tension, and revealed the difficulties of negotiating lay and expert knowledge and embodied, affective experience.

The tensions between the knowledges that partners drew on in their management of risk could also shape couples’ health practices and outcomes in material ways. Even though George accepted Susan as the ‘health expert’ within their relationship, her influence operated within the constraints of relationship, and possibly gendered, norms. Although Susan had suspected that George was having a heart attack on the day that he fell ill, she regulated her response according to relationship norms of consent and independence, and the power differential between lay and expert knowledge:

Susan: I’m not a medical person I I I really don’t know and (.) so I I didn’t know what was the matter with him (.) plus the other thing that was erm (.) hard was that he wouldn’t want any fuss (.) you know he’s not someone who wants you to fuss or if I say

(..) oh I'll dial 999 I thought it might be something that keels him over the (.) end or he might start saying so I just said tentatively (.) tentatively (.) erm actually I'm going ring (.) just stay there a minute put a blanket over him stay there a minute and I I'm going to ring for some advice I just knew he was ill (.) I knew he was ill I didn't know what it was and I feared heart attack but there was nothing there there was no pains in the chest erm so I went through the local out of hours GP service (.) and the worst part of that was the 40 45 minute wait for (.) a professional to come on the line to give him the phone for him to describe what was the matter (Int.1.11.370-385)

Susan was reluctant to assert her understanding of his illness. She distanced herself from the expert position of '*a medical person*', and constructed medical knowledge as certain and decisive in contrast to her own uncertain, affective response: '*I didn't really know*' and '*I feared heart attack*'. A further barrier to her taking control of the situation was her understanding of George's wishes, and her fear that her action could have been risky, '*it might be something that keels him over*'. She predicted and circumvented his resistance by minimising her intervention and accessing '*advice*' through non-emergency rather than emergency services. There were affective and material costs to them both. The long wait to speak to the '*professional*' was the '*worst part*' of a traumatic experience for Susan, and there was a potentially life-threatening delay in diagnosis in order not to violate George's autonomy over his own health.

Using Foucault's (1988, 1989) concept of fragile, local, and reversible power relations that circulate between people in relation to the status of different types of knowledge, we can understand Susan as in possession of knowledge, yet frustratingly helpless. Despite her recognition of the seriousness of George's condition, her knowledge was subordinate to medical expertise. Susan constructed the '*professional*' as distinct and superior to her own non-professional role, and she was excluded from the interaction; she gave George the phone so he could describe his own symptoms. Susan's deferral to expert, professional knowledge and to George's autonomy denied her an active role in the management of the situation. George later said '*I owe my life to her there's no doubt of that*' and '*she was the only one who knew*' (Int.1.11.407), but during his acute cardiac event, Susan had to choose

between evoking resistance or distress that might have worsened his condition or even precipitated his death, and the long wait for help which also put him at risk.

In this section I have explored the circulation of different kinds of knowledge: lay, expert, medical, and experiential, in participants' talk of their health and illness. These different kinds of knowledge produced different analyses of risk, and expert knowledge in particular was drawn on to legitimise practices and positions relating to lifestyle and medical management, in the construction of a form of 'lay expertise' (Hall, Grogan & Gough, 2015; Lupton & Petersen, 1995). The outcome was a need for participants to negotiate different assessments of risk management while conforming to relationship norms, that, as discussed in chapter 7, are also multiple, orienting around care, concern, a moral duty to intervene, yet also respectful of autonomy and non-coercive. Conflict could arise for the participants as they negotiated these multiple and sometimes contradictory evaluations of risk, types of knowledge, and relationship norms. Participants drew on different types of knowledge at different times to inform their risk and health management, which could be adopted or resisted as partners legitimised their respective positions through claims to expert knowledge.

Part of the conditions of possibility for multiple knowledges and constructions of risk was the way medical knowledge was understood as complex, uncertain, incomplete, and liable to change. These constructions delineated the limitations and contradictions in medical and scientific knowledge, which I explore in the following section in an analysis of how participants negotiated the boundaries and capacities of medical discourses to explain or account for their illness or to guide their lifestyle change.

8.2 The Limits of Expert Knowledge.

Participants were caught between two contradictory aspects of expert knowledge. Medical, scientific knowledge was looked to for explanations of illness and calculations of risk, and used to bolster or legitimise their positions and practices. But participants also constructed it as partial, not specific to their circumstances, and sometimes contradictory. This latter understanding highlighted the limits of expert knowledge to explain causality and offer the promise of control.

In the extracts below, for example, Louise established the importance of knowledge in the processes of recovery and regaining control, particularly for her own identity:

Louise: but my biggest concern and the part that makes me crazy (.) I mean crazy crazy it's crazy making (.) is I don't have answers and I am an answer person (Int.1.ll.437-440)

Louise: that's part of who I am I want to know why and the biggest emotional factor I have in all of this is is it because I walked up the hill is it because I had a spam sandwich that day is it because I wasn't drinking enough water is it because something I had no control over is it was I doing something wrong (.) was I doing something that you know what caused it what's the reason and I think that's the part I have the hardest time that's the hardest issue I have to deal with and I also understand I may never this side of the grave get an answer for that (Int.1.ll.481-490)

In the first extract, Louise drew on neoliberal discourses of knowledge as essential to risk management and an appropriate health identity. She claimed that a lack of answers was her '*biggest concern*' after her diagnosis, establishing a link between knowledge, risk and safety. A lack of knowledge troubled her identity as '*an answer person*', a rational, self-governing health citizen, and was productive of an opposite self – '*it's crazy making*'. For Louise, the lack of answers blocked her path to understanding and thus a measure of control, and her multiple repetitions of '*crazy*' constructed an extreme, incoherent, and irrational self, and her intense frustration at this positioning.

In the second extract, Louise's unfulfilled expectations of medical experts related to specificity and causality, with the implication that knowing the cause of her heart disease would also allow her to apportion blame, and control future risks. Her three-part list of possible causes all located responsibility with Louise herself, with the repetition of '*I*' and the listing of dietary and lifestyle practices, such as eating the '*wrong*' food, or over-exerting herself, that may have caused her illness. She briefly considered a random cause, '*something I had no control over*', before returning to a direct attribution of blame and moral judgement in her designation of her actions as '*something wrong*'. This structure, where an alternative position is '*sandwiched*' between more conventional positions (Riley, 2002, 2003), allowed Louise to air less acceptable or more radical statements whilst still adhering to

normative understandings of health and illness. Although she adopted neoliberal understandings of health as ‘occasioned by the self’ (Stacey, 1997, p.175), and consequent implications of blame, Louise was also able to articulate a position that deflected self-blame with her appeal to a cause beyond her control.

Her extreme-case formulations of ‘*never*’ and ‘*hardest*’ constructed her frustration at the absence of certainty, which affected her powerfully as she grappled with what can be known, understood, and accepted in light of her identity as ‘*an answer person*’. Louise’s evocation of death in her reference to ‘*this side of the grave*’ evoked both the risk and precariousness produced by an absence of certainty and control, but also the limitations of medical science to give her the answers she wants. Despite her frustration at the limits of medical knowledge, her statement ‘*and I also understand I may never this side of the grave get an answer for that*’ suggests an alternative construction that hints at the power of acceptance. Although partial and forced upon her, Louise deterritorialised dominant health discourses that equate knowledge with control, and to some extent accepted uncertainty. In exploring the limits of expert knowledge, acceptance thus appears to offer an affirmative response to the unknowability of the body and its processes of illness and health that is absent in neoliberal healthism (Gard & Wright, 2001), an issue I explore further in chapter 9.

A further limitation of expert knowledge relates to a prediction made by Crawford (2006) that the current intense focus on health and risk, and pervasive, multiple and conflicting information, would produce cynicism and fatigue. This prediction is supported with research that suggests that people can experience health advice as disempowering (Murphy, 2003; Shepherd, 2014). Equally in this study, participants constructed health information as difficult to evaluate, trust, and follow. See for example, Eddie’s extract above discussing contradictory media reports on statins.

Scientific knowledge and lifestyle advice are themselves contested and conflicted (Kromhaut, 2016), and patients and partners oriented to these contradictions and complexities in their management of lifestyle change. In the

following extract, Henry and Catherine were talking about the multiplicity and changeability of health information, and particularly dietary advice:

Henry: well if you believe everything that's said on television you'd never do anything would you so yeah (Int.2.ll.651-652)

Henry's extreme-case formulations 'everything', 'never', 'anything' built an account of health advice as prohibitive and impossible to follow. His construction of health information from media sources as paralysing legitimised mistrust and non-engagement in the advice. Catherine suggested the internet as a more personalised or reliable source, which Henry also resists:

Henry: I suppose yeah I never thought about that but I suppose you could do yeah but then again there would be different opinions wouldn't there and some people get different ideas so yeah but er [so it's] I mean they do come out with all these ridiculous things that you can't eat this it's bad for you you shouldn't do this you shouldn't do that (.) you know as I say if you took note of all that they say you should or shouldn't do then (Int.2.ll.661-668)

It is the multiplicity of health prohibitions as well as the restrictiveness that Henry oriented to as extreme and untenable. Health information was not constructed here as universal, objective and uncontested, but consisted of 'different opinions' and 'different ideas', subjective and conflicting. He disparaged the multiplicity and content of health advice, 'all these ridiculous things', with the implication that it would be foolish to follow these injunctions. He reinforced the prohibitive nature of advice that blocks action and limits consumption in his three-part list, 'can't...shouldn't...shouldn't', producing constraint, a reduction in one's powers of acting which for Henry is unequivocally negative. Henry constructed the health advice as an enumeration of what is 'bad for you', a message of fear and risk which is avoidant of negative outcomes rather than affirmative or productive of health.

As a partner who took on responsibility for changing their diet, Catherine voiced the difficulty of keeping up with even such apparently straightforward advice as the 'five-a-day' campaign that encourages the consumption of at least five servings of fruit and/or vegetables a day:

Catherine: yeah 'cause it's seven seven a day now isn't it instead of five a day mmm...

Henry: yeah yeah with the fruit and veg yeah yeah which I do I mean like

Catherine: but it's not understandable because you go seven a day alright one pea one one one sweetcorn one ((laughter)) is that my seven a day (Int.2.ll.670-681).

Catherine referred to changes from the recommended five-a-day to seven portions of fruit and vegetables a day. The campaign offers an apparently simple, memorable guideline that reinforces understandings of health behaviour change as straightforward and easy to achieve. But the change from five to seven illustrates the mutability of expert knowledge, undermining the notion of scientific knowledge as consisting of stable, universal truths. Henry transformed the specifics of five- or seven-a-day into the broad category '*fruit and veg*' which he suggests he is able to achieve and enjoy. But Catherine, as in her earlier negotiation of the advice to eat red meat only twice a week, uncovered the complexity inherent in apparently simple health guidelines (Lupton & Petersen, 1995), and the material dilemmas that an engagement with this advice produced. Both Henry and Catherine's oriented to lifestyle advice as difficult if not impossible to follow, which built an account of healthy lifestyle advice as uncertain and allowed them to maintain positions of reasonableness and rationality even if they do not incorporate expert knowledge into their management of their own lifestyle and risks. A consideration of how expert knowledge is both adopted and resisted offers insight into the variability with which lifestyle changes are initiated maintained by couples with heart disease (Cole et al., 2013; Goldsmith et al., 2006; Radley & Green, 1986).

Above, I explored how participants sought knowledge, but knowledge that was personal and specific to them and their illness and recovery, and in doing so, reached some of the limits of expert, scientific knowledge to account for their illness and inform their risk management (Lupton & Petersen, 1995). Participants responded to these limits sometimes with cynicism, but sometimes with acceptance of uncertainty. These responses offered deterritorialisations or line of flight from the cycle of anxiety and control in which some participants and partners were captured in their

awareness and attempts to manage health risks. In the next section, I examine how couples' own experiential knowledge and their intimate knowledge of each other, built up over their relationship, combine to produce multiple knowledges, which can be resisted or accepted by partners and health care professionals.

8.3 Multiple Knowledges and the Management of Lifestyle Risk.

The elaborate 'lay epidemiology' which people develop in their understandings of health and illness disrupts traditional divisions between lay and expert knowledge (Crawford, 2006; Davison et al., 1991; Hall et al., 2015). In this study, couples drew on multiple knowledges, which included factual and scientific knowledge as well as experiential, embodied, affective kinds of knowing in their management of risk. Their knowledge was negotiated dynamically between the partners, and occasionally their health care providers, in complex ways that challenged simplistic, information-transmission models of the ways that risk is assessed and health advice is taken up. Participants balanced their intimate knowledge of themselves and their partners against broader social and expert discourses of healthy living, and negotiated the legitimacy of different knowledges. The ensuing local, reversible power relations produced preferred and dispreferred subject positions that partners inhabited, resisted, and sometimes transformed.

Couples' knowledge of each other was not infallible or always complete. They co-construct different knowledges, which as with expert knowledge in the section above, produce power relations that circulated and were negotiated in intricate patterns as couples manage lifestyle risks. Sometimes ineffable, affective responses are incompletely captured or accounted for by a partner's as well as by expert knowledge, as when exercise, for example may be constructed as a risk by one partner, and as curative and protective by another. In the section below, Paul expressed reservations about attending the cardiac rehabilitation class, which Ellen attempted to account for in ways that Paul resisted:

Ellen: we're waiting now to go to rehab aren't we in the next chapter in the book I think

Paul: I'm not looking forward to it

- Ellen:* *he says I haven't been to I haven't been to a um to a gym since I was at school [laughs]*
- Int:* *so why aren't you looking forward to it do you think*
- Paul:* *I (.) I don't know really*
- Ellen:* *you are (.) you are embarrassed that's what it'll be ((laughs))*
- Paul:* *I don't know I think [it's*
- Ellen:* *[I shall come and have a laugh*
- Paul:* *not the fear of the unknown but it's something I don't know what I'm going to have to do*
- Int:* *right*
- Ellen:* *yes but you see*
- Paul:* *so*
- Ellen:* *he says they work you think you're going to get stressed you if you have to do weightlifting or or*
- Paul:* *there won't be weightlifting*
- Ellen:* *or walking round or what have you well you've got to strengthen something over your shoulders 'cause they need strengthening I feel (.) but um that's only my personal I'm not a medic*
- Paul:* *right*
- Ellen:* *but so they're not going to let you do more than they can see [you can cope with*
- Paul:* *[no I know I know that but I still I don't really want to do it but I'll do it*
- Ellen:* *yes yes we will go* (Int.1.11.237-261)

Paul initially expressed his concern about starting cardiac rehabilitation classes, and Ellen used her knowledge of Paul to guess at the cause of his discomfort – a fear of embarrassment. Ellen positioned herself as knowledgeable, but Paul resisted her claims, despite not being able to articulate his undefinable apprehension about the class. Ellen went on to attribute his reluctance to a fear of over-exertion in

an attempt to rationalise and name Paul's affective response. He also rejected this attempt to make the ineffable more concrete, both in his direct refutation of her claim that he was worried about being overtaxed, and more indirectly when he concurred with her retreat from an expert position, '*I'm not a medic*'. Deleuze does not distinguish between emotion and reason, knowledge and experience, arguing that knowledge is always experiential and affective, 'grasped in a range of affective tones: wonder, love, hatred, and suffering (1994, p.139). Paul 'knew' that he wouldn't have to do weightlifting, and that he wouldn't be pushed beyond his strength, but his contemplation of the class nonetheless evoked a negative affective response, that was not fully captured by the explanations Ellen proffered.

Ellen drew on an embodied knowledge of Paul when she constructed the exercise class as therapeutic. She talked about his need to strengthen his shoulders, a claim to an intimate understanding of his body, its capacities and deficits, although she constructed this knowledge as potentially inferior, however, in her disavowal of medical expertise. Her repair also signalled that her observation may have conflicted with relationship norms of acceptance and support. His agreement, '*right*', as with his previous rebuttals, resisted her claim to expert knowledge and indicated that Ellen may have overstepped some boundary in her 'diagnosis' of his physical deficits. This pattern was repeated when he refused her offer of reassurance for a barely articulated fear that he will be overtaxed. His '*I know*' shut down her claim to superior knowledge, levelling any disparity in their knowledge and positions, and asserting his affective response to the class in an unarguable way. It cannot be rationally explained or explained away, but contemplating the class was dysphoric for Paul. These affects were grounded in his post-surgical, embodied experience of reduced capacities and anticipation of physical exertion of a body in which he has not yet regained full confidence. Partners' knowledge is an intricate mix of expert and experiential that disrupts traditional dichotomies, but just as expert knowledge failed to provide the answers Louise sought, Ellen's knowledge could not speak to or alter Paul's affective response.

Even when couples accept each other's expertise and evaluations of risk, power relations still circulated between them, evoking resistance, but also producing affirmative ways of being together as in the extract below. Earlier in their interview,

Graham had demonstrated a familiarity not just with Holly's current eating habits and preferences, but with the family history upon which they were based. The poverty and limited range of food that characterised her childhood constructed a long history of risky eating that persisted to the present. But Graham's knowledge of Holly's eating was also 'scientific' as well as experiential:

Holly: 'cause I mean nobody's give us dietary nothing and that has been worrying me

Graham: yeah well you have to I mean I

Holly: but he's experimented and I I've fed his I give you praise

Graham: I do 'cause I have some grey matter and I can

Holly: he's worked it out himself you know and he's he's improvising

Graham: we're quite switched on about nutrition and and (..) so I make sure that she gets what she needs and (...)

Holly: I have lost a bit of weight through the last year

Graham: she she's only 53 kilos you were in hospital which is only eight stone something and you're quite she she's quite tall

(Int.1.11.210-230)

Above, Graham's expertise was constructed by Holly through her acknowledgement of his experimentation and improvisation, and through Graham's own claims to have 'grey matter' and be 'switched on'. Graham's talk positioned him within neoliberal ideals of conformity to appropriate health practices, and also of autonomy and independence. They had not received dietary advice from health care professionals, according to Holly, but he drew on his intelligence, creativity and knowledge about food to meet Holly's nutritional needs. Graham included Holly in this positive health identity, 'we're quite switched on', despite their earlier acknowledgement of her resistance to healthy eating. Their monitoring of her weight also indicated their joint engagement in appropriate health practices, based on understandings of weight and diet as representing health risks and solutions. Holly praised him for his attempts to influence her diet, indicating that his knowledge is valued and admired, though not always followed as the extract below illustrates:

Graham: *you you don't eat enough veg*

Holly: *no I don't (..) I I will agree with that that's why I bought that salad stuff the other day (.) 'cause I thought well*

Graham: *that's still sat in the fridge*

*Holly: it's in the fridge it's ready (..) I'll eat it when I feel like it or
Graham'll come in and say do you know how long this has
been in the fridge no but you're going to tell me anyway it's
off oh better throw it out then (Int.1.11.339-349)*

Holly was aware of all the risks and risky identities she inhabited, but she resisted them in her account of the habitual buying and not eating healthy items, ‘*that salad stuff*’, which reflected Crawford’s (2006) observation that health injunctions are knowingly violated, and evidence that there is no linear simple relationship between knowledge and health behaviour (Farrimond et al., 2010). Cognitive models may indicate a linear relationship between knowledge and behaviour, but the couples in this study demonstrate that behaviour is affective, a response to multiple imperatives and desires in ways that makes each person’s response to health information and advice highly individual and personal.

Participants' intense sense of uniqueness formed a recurring pattern through the data. Almost none of them regarded themselves to be a 'typical' heart attack patient, constructing their risk factors, symptoms, and recovery as highly individual and idiosyncratic. The ramifications of this discourse included a resistance to or rejection of health and lifestyle advice that is generalised rather than personalised to their needs (Lupton & Petersen, 1995). They negotiated these understandings with their partners in the context of receiving health care and advice from nurses and doctors, and here Holly and Graham contrast expert medical and their own personal, embodied, affective knowledge of each other that they use to construct their own cost/benefit risk analysis relating to behaviours such as diet and smoking:

Graham: it's a problem doctors have in their training I think that they're not they're they're trained to solve the problem but they don't seem to be ever concerned about the state people might get in or

Holly: well yeah I think you're right there because I mean it's like with the body it's like with the person isn't it everybody is different (Int.1.ll.1261-1278)

Graham problematized medical knowledge for its focus on intellectual problem solving, and consequent lack of attention to people's affective responses. He constructed a dichotomy between mind and emotion, an impasse in which the intellectual skills that doctors acquire reduce their capacities to care, empathise, and see patients as individuals. Holly broke down the body/person divide that she attributed to doctors, and asserted the uniqueness and indivisibility of both, '*like with the body it's like with the person...everybody is different*'. For Deleuze (1994), difference lies at the heart of existence, not a differing from some prototypical ideal, but a difference in itself, the process of differing, moment by moment which constitutes life itself. When Holly said '*everybody is different*' she captured not individuals who differ from a norm in a pejorative way, but rather evoked Deleuze's pure difference, the production of unpredictable novelty which demands a recognition of and respect for uniqueness. This notion of difference resists the generalising tendencies of medical science, which creates challenges for patients, but also for policy makers who assert the value of patient-centred medicine (Mol, 2007; NICE, 2012), and for doctors who apply population-level research findings to individual cases to determine what constitutes the best care for individuals (Aronson, 2016).

Graham and Holly reinforced the value of a personal, holistic approach to risk management, and identify further limitations of medical knowledge compared with their own multifaceted understanding of Holly's illness:

Graham: but they do they do see patients as erm (.) something to stimulate their brains in a way rather than they don't I don't think they give much thought to the erm stress on patients erm

Holly: well they they don't

Graham: of their condition or having to wait for things to be done

Holly: or you go in and you think okay you know there's something wrong (.) but they don't because they're not living in your body so they can only do what they're told what they think it is you know and until they've got that diagnosed you know they thought that there was nothing wrong with me just my heart

valve I didn't think when he cut er in to do the angiogram (.) he says oh I wasn't expecting that (..) and I thought I can't be arsed to ask you know then he says oh he says it's a load of cholesterol built up here he said let's go further up and he was absolutely brilliant he went up to my heart and he says oh I wasn't expecting that neither nor that and I thought (.) but I was (ll.1194-1214)

Graham reiterated the polarity of different types of knowledge and caring, and constructed medical knowledge as intellectual and disembodied '*something to stimulate their brains*', removed from patients' affective experiences. For Holly, this disconnection from their patients accounted for the limitations of their knowledge. She claimed that doctors could not have direct access to the embodied experience that formed her understanding of her health, '*they're not living in your body*'. These different knowledges set up reversible, local power relations not just between partners, but between patients and individual health care professionals. As an institution, medicine's power emanates from its production of scientific knowledge and expertise, but on an individual level, doctors are subject to the same discourses, uncertainties, and power relations as lay people (Hansen & Easthope, 2007). When Holly constructed doctors' knowledge as partial and removed from the vital bodies they examine, she constructed a diminished scope and power for what doctors can do, '*they can only do what they're told*'. Compared with her own embodied knowledge, medical knowledge was uncertain ('*they think*') and she reported her doctor's surprise at the clinical findings and diagnosis in her case. Despite her claim to superior knowledge of her body, these power relations were not stable. When the doctor expressed surprise during the angiogram (a test where radio-opaque dye is injected into the arteries so the blood supply to the heart muscle can be assessed), he did not immediately explain what he had found, and Holly didn't, or couldn't question him. Again, at the end when the doctor said '*I wasn't expecting that*', she thought, but did not say '*I was*'.

The divide between couples' and medical professionals' knowledge could, however, be bridged by empathy. In the following extract, Graham and Holly's recounted a negotiation between their own and their doctor's expert, scientific knowledge. Holly had not been able to give up smoking after her diagnosis with CHD, and justified this by constructing her smoking as minimal (5 or 6 cigarettes a

day) and as an essential part of her stress-management strategy, and Graham talked about the doctor's reaction to Holly's smoking and diet:

Graham: I think the doc the doctor's (.) kind of unofficial attitude to (..) smoking and and eating the wrong things is okay and and the doctor's never going to say carrying on smoking but I think his view has been (.) you've got so much wrong with you and if it does that little bit to de-stress you then (.)

Holly: it does help

Graham: it'll cause more problems probably in a way (Int.1.ll.380-389)

Their account of the doctor's response introduced a new form of knowledge, one that was negotiated between patient and doctor, and which found a common ground between 'official' medical knowledge and advice, which would never condone smoking, and Holly and Graham's experience of diet and smoking as part of an assemblage that included an intricate, affective coping strategy. In contrast to understandings of lay and medical knowledge as distinct and often oppositional, Hansen and Easthope (2007) argue that doctors' constructions of lifestyle and health are nuanced, and constituted in similar ways to lay understandings. It seemed that the doctor's 'okay' signalled an acceptance of or at least a recognition of Holly's justification. According to Graham, the doctor's concession encompassed an acknowledgement of Holly's suffering, and a concern for her stress. This response was in contrast to the Graham's earlier statement that doctors 'aren't concerned about the state people might get in'. In coming closer to the couple's embodied, affective experience, Graham constructed the doctor as able to overcome the boundaries of a purely intellectual, rational position, and access empathy and concern. When Holly said 'it does help', she may have been referring to her smoking, but also possibly to the affirmation of her experience by a medical professional.

There is a multiplicity and layering to participants' knowledge and health practices. They manage their awareness of what constitutes a healthy preventative diet alongside a recognition of their own and their partners' unique needs and desires. The multiplicity of assemblages of health encompasses understandings of food, weight and other risks, such as smoking, as healthy as well as unhealthy, and

couples negotiate the resulting intricacy and paradoxes in their joint management of risk, and provides an alternative lens through which to understand patterns of adoption and resistance to healthy lifestyle advice by couples with heart disease (Cole et al., 2013; Franks et al., 2006; Radley, 1988)

8.4 Discussion.

Traditionally, knowledge is defined through a range of dichotomies: experiential and declarative, knowing how and knowing that, subjective and objective. These dichotomies map onto understandings of lay and expert medical knowledge (Hansen & Easthope, 2007). But the participating couples' shared knowledge troubled these binaries and categories since it was all of these things, experiential, expert, affective, and embodied. They shared physical experiences, observations, emotions, and negotiations over time, but they also incorporated 'scientific' knowledge into their intimate knowledge of their partner's health. It is this knowledge that provided coherence to their health behaviours, rather than the logic of neoliberal, rational risk-management. Couples drew on multiple knowledges in their management of their partners' health and health risks, which were negotiated in fluid ways with partners and with health care professionals. Butler (1997) argues that agency relates not to freedom to act, but in the ways that discourses and positions are adopted and resisted, and certainly partners' knowledge was not passively accepted. Participants adopted and affirmed, but also at times rejected not only their partners' claim to expert, but also their experiential knowledge of each other.

Participants drew on expert discourses both as partners and patients, as expert, scientific knowledge was used to legitimize their positions and practices (Hall et al., 2015). Couples oriented to scientific knowledge as universal, objective, and unarguable, but there was potential for conflict when couples drew on different strands of medical information to bolster divergent positions and practices, as when Lily enumerated the benefits of medication to encourage Eddie's compliance, and Eddie referred to risks and side effects to warrant his dislike of taking statins. The authority conferred by use of scientific or psychological language legitimised a level of control which might otherwise transgress relationship norms of support and

acceptance (Goldsmith et al., 2012; Stenner & Watts, 2005), and the outcome was that couples negotiated a shifting boundary between caring and control that is evident in mainstream literature (Franks et al., 2006; Murray et al., 2006; Tucker & Anders, 2001)

In fulfilling relationship norms of concern for each other's health, and in their positions as well-informed 'expert' patients and partners, they also enacted a form of power, hinted at in Dan's implication that he could put his foot down and insist on Louise taking her medication. Foucault argues, however, that power is never confined to a particular group, commodity, or person, and 'not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising power. They are not only its inert or consenting target; they are always also the elements of its articulation' (1980, p.98). This power is not possessed by one partner or the other, but circulated between them as the legitimacy of their knowledge shifted throughout their interactions, forming what Foucault termed, 'a purely local form of reversible power' (Foucault, 1988, n.p.). The critical approach of this thesis develops the theorisation of couples' power relations, which illuminates the interactive patterns identified in mainstream literature (Lewis & Butterfield, 2007; Robles et al., 2014), and develops understandings of intimate relationships as sites of the formation and reproduction of health-related social norms and identities (Finn 2005, 2010; Rose, 1999).

Participants whose partners have a diagnosis of CHD managed conflicts in their shared and different knowledge and evaluation of risk, but also the limitations and contradictions of medical and scientific knowledge. Crawford (2006) predicted that the current intense focus on health and risk, through pervasive, multiple and conflicting information, would produce cynicism and fatigue. This prediction is supported with research that suggests that people can experience health advice as disempowering (Murphy, 2003; Shepherd, 2014), and in this study, at times participants constructed health information as difficult to evaluate, trust, and follow. Medical knowledge is predicated on generalisability which identifies population-level patterns rather than individualised answers, and participants had to negotiate the resulting uncertainties in their search for information that was personal and relevant to them (Kromhaut, 2016; McCarthy, 2016). Health promotion is predicated

on achieving good mental and physical health through recommended lifestyle practices, but Crawford (2006) argues that the result of risk awareness is a cycle of anxiety and control. This thesis supports, but also develops Crawford's premise by demonstrating how individual risk management became joint, as couples negotiated their own and their partners' health risks in the context of CHD. This analysis develops conceptualisations of couple health interactions beyond the categories of positive or negative, or even ambivalence (Birmingham et al., 2015). Using Deleuze and Guattari's (1987) notion of deterritorialisation indicates that, although couples' accounts reflected the anxiety that Crawford predicted, they also deterritorialised the promise and fear of risk management, sometimes drawing on fatalism, but also a more affirmative acceptance of uncertainty and complexity in the face of the indeterminacy of the causation and prognosis of their condition.

Both Deleuze and Foucault conceptualised knowledge in ways that offer insights into the ways that couples draw on different knowledges in their management of risk. Foucault provides a framework for thinking about knowledge as discourses which are situated in time and place, contingent rather than stable and universal. Some discourses are privileged over others, creating power relations between dominant and 'subjugated knowledges...located low down on the hierarchy, beneath the required level of scientificity...unqualified, even directly disqualified knowledges' (Foucault, 1980, p.82). Foucault acknowledged the materiality of these power relations, that have a clear application in the way that couples negotiate different kinds of expert, medical, and experiential knowledge and the ways in which people are brought to work on themselves through their diet, medication and exercise regimes.

In terms of intimate knowledge, health behaviour and risk management, Deleuze's concepts of assemblage, multiplicity, affect and desire allow us to think of knowledge not as singular, rational, objective universal truths but as multiple, affective, embodied, and experiential. Deleuze drew on Spinoza's monism to challenge the implications and ramifications of Cartesian dualism and transcendence in his assertion that 'seeing and speaking means knowing...Everything is knowledge' (Deleuze, 1988, p.109). His concept of knowledge captures the multiple dimensions of couples' knowledge and the practices, positions, and subjectivities it

affords. Deleuze's thus offers a more egalitarian model than the hierarchical knowledge that subjugates lay knowledge to expert, scientific knowledge, in his recognition of knowledge as multiple and multifaceted.

Health advice suggests that lifestyle change is easy to institute and to maintain. Peoples' inability to achieve stable healthy lifestyle is understood as irrational, a failure to properly evaluate risk, or to exert appropriate self-control (Tischner & Malson, 2012). But in these interviews, participants' intimate knowledge of each other formed dynamic relations with other aspects of their joint endeavour. It informed their understanding and negotiation and management of risk, and was itself shaped by the fluidity of actual experience, as they made and remade their knowledge in the light of contradictory neoliberal and biomedical discourses of health, and of their own interconnected and embodied experiences. In the following chapter, I will explore this fluidity further in the ways that couples talk about time, health, illness, and death.

Chapter 9: Multiple Temporalities of Lifestyle

Introduction.

In previous chapters, I examined how couples negotiated understandings of healthy living as a joint endeavour, and how, within this broad construction, they managed risks relating to food, exercise and health. In their risk management, they adopted, resisted and occasionally transformed dominant health discourses. They drew on embodied, experiential knowledge of each other, and also upon ‘expert’ medical knowledge. Tensions arose in partners’ negotiations of their sometimes differing understandings of risk, and between the different types of knowledge that informed their positions and practices. Participants also occasionally deterritorialised dominant neoliberal understandings of lifestyle - risk as something an individual can and should control. They asserted other values and ways of being, such as accepting the limits of scientific knowledge, and of personal control and responsibility. Their construction of scientific knowledge and health as fluid and uncertain leads into the final theme in the data analysis, which explores the temporal dimension of the way that participants’ talk of health and illness.

Dominant health discourses construct health as a stable state, produced through adherence to a healthy lifestyle that is simple to achieve and maintain (Hansen & Easthope, 2007; Lupton, 2014). Within these discourses, time is absent, or only implicitly present in notions of becoming more or less healthy through reversible changes in lifestyle (e.g. the Change4Life campaign). Academic literature dealing with patients’ experience also rarely addresses issues of time (Stronge, 2012). An exception is Radley (1996) who discusses the importance of time – future hopes and fears, variations in the timing of each other’s expectations of and anxieties about recovery – which complicates the relations between partners as they cope and adjust to a diagnosis of CHD.

Poststructuralist theories of time have only applied to health in limited literature. For example, Annemarie Mol (1999) drew on Deleuze and Bergson’s theories to conceptualise patients’ experiences of time in the context of anaemia,

proposing that multiple, co-existing and distinct realities of disease ‘are different versions, different performances, different realities that co-exist in the present’ (p.79). This concept of parallel time frames has also been applied to health screening which ‘involves a dense multiplicity of durations’ of past, present and future health and illness that can ‘trade places, blur, slide into one another, and occasionally come into conflict in an unending and fluid process’ (Stronge, 2012, p. 354). Similarly, in her study of temporalities of dieting, Coleman (2010) argues that different parts of dieting websites create multiple understandings of dieting that have clear temporal dimensions. For example, websites acknowledge that dieters will make multiple attempts to lose weight, and bring the future desired self/body temporally closer to the present self. In this way, such websites recognise and normalise fluid, multiple temporalities of diet and weight loss as people begin, abandon, and recommence their diets.

There was also a strong temporal dimension in participants’ accounts in this study. Partners made frequent references to time and drew on past as well as present and future capacities in ways that made these different moments in time relevant and ‘real’ at that moment. In drawing on multiple time frames when considering their or their partner’s current illness, participants thus constructed lifestyle change and health as fluid and ephemeral. Such accounts challenge conceptualisations of time as linear and unitary, and the promise in health promotion and advice of sustainable health based on long-term adherence to the principles of healthy living (Stronge, 2012; also see chapter 2).

Although limited and scattered, poststructuralist-informed work, particularly that which draws on Deleuze’s notion of multiple realities and temporalities of health, provides a useful framework for examining the multiple time frames in health-related sense making. For example, Annemarie Mol (1999) argues that Foucault’s assertion of the performativity and situatedness of reality is also predicated upon multiplicity, since ‘if reality is done, if it is historically, culturally and historically located, then it is also multiple’ (p.75). She uses the example of a body undergoing medical procedures to argue for multiplicity that is enacted through practices rather than observed. In surgery or ultrasound where here ‘it is a fleshy object, there one that is thick and opaque...they are different versions of the object,

versions that the tools help to enact' (p.77). Multiplicity involves many relations between conflicting or interdependent realities, allowing for an analysis of couples' accounts of co-managing lifestyle change in the context of multiple time frames, including the trajectory of their CHD, their diagnosis, treatment, and recovery, as well as their lifespan and other disease and ageing processes that they experienced. In such talk, participants moved fluidly between these temporal experiences in ways that created multiple subject positions. For example, in data presented later in this chapter, Catherine drew on a past, athletic self to bolster against the gap that opened up between her and Henry's physical capacities during his attendance of a cardiac rehabilitation class, while Carl envisaged a future of limitless possibility with his mended '*unburstable*' heart. These fluid constructions of time warranted varied health practices, and constructed a sense of indeterminacy and uncertainty that shaped what participants said, thought and felt in relation to their experiences of lifestyle change and recovery from the diagnosis and treatment of their CHD.

In this chapter, I explore how this indeterminacy and uncertainty was negotiated in couples' construction of the fluidity of illness, health and healthy living. To do so, I describe three discourses that articulate the key ways that the participants constructed their experience of time in relation to health and illness, entitled 'Lifestyle change: Multiple, unfixed and unfolding', 'Temporal selves: Plural timeframes of recovery' and 'Death comes to us all'. I use a Foucauldian discourse analysis to examine how couples' talk in these discourses construct fluidity and uncertainty against a backdrop of wider discourses of health and healthy living as stable and controllable. I then draw on Deleuze's argument for the co-existence and accessibility of past and future when he writes that 'there is no present that is not haunted by a past and a future, by a past that is not reducible to a former present, by a future that does not consist of a present to come' (2005, p.36).

Deleuze's concept of time affords a recognition of co-existing and distinct realities of disease as 'different versions, different performances, different realities that co-exist in the present' (Mol, 1999, p.79), and provides a framework for thinking about the ways that couples talk about time in relation to lifestyle change, recovery and death. By combining FDA with concepts from Deleuze's process ontology and notions of time, the analysis below demonstrates the fluid ways that

participants drew on past, present and future selves in their negotiations of lifestyle change. These parallel, multiple realities and durations structured partners' understandings of health, illness, and relationships that aligned with or challenged wider discourses of health. I conclude by considering the implications of participants' constructions of time for increasing or diminishing their engagement in lifestyle change, and how their lines of flight away from dominant understandings of time, health and healthy living produced new values and ways of being.

9.1 Lifestyle Change: Multiple, Unfixed, and Unfolding.

In this discourse, time was salient in the way that participants constructed lifestyle change as inherently short-term and unsustainable. But time is also an element in the fluidity with which they switched between different constructions as they negotiated the contradictions of understandings of lifestyle change as simultaneously effortful and simple, valuable and futile, sometimes negative, but also affirmative as when, as for example, exercise opened up new capacities and ways of being for patients and partners. Participants adopted and resisted these conflicting discourses over an interview or series of interviews, and even sometimes in the same interchange. From a Deleuzian standpoint, the dynamism of participants' health interactions can be understood as an unfolding of novel relations rather than a predictable pattern of behaviour. An example of this dynamic can be seen in the extract below that focuses on the sustainability of joint and individual engagement in exercise.

Most participants talked positively about the value of exercise, but simultaneously constructed it as effortful, not fully within individuals' control, and ultimately short term and unlikely to be sustained. Here Tom (late 70s, self-employed) and May (early 60s, retired public service worker) talked about why they had not been taking the daily walks they had planned:

- Tom:* *there and back that would be one that would be then two miles and I was doing that for a while but then the weather gets you*
- May:* *yes yes it's all right on nice days but then when you have you know (.) yes so*

Tom: *the weather gets you then and suddenly you stop and and also you get a cold and various other odd things happen that you it it drops off*

May: *and then life takes over doesn't it*

Tom: *yeah that's right*

May: *all the things that you know (.) just come and*
(Int.1.ll.400-415)

They built an account of their exercise regime as short term. This unsustainability was attributed to uncontrollable external factors, such as the weather, deflecting possible attributions to a lack of commitment on their part. Tom's repetition of '*the weather gets you*' positioned him as helpless to contend against powerful elemental forces, and time phrases such as '*for a while*', '*suddenly*', and '*but then*' built a sense of discontinuity and interruption. Tom and May's contention that exercise is contingent upon fine weather relegated exercise to an irregular occurrence in the context of living in Wales. Exercise was ephemeral; it was not valued enough to be persisted with when the weather is not conducive. In Deleuzian terms, the weather formed part of an assemblage of exercise. Tom evoked the physical discomfort of exercising in cold or wet weather as disempowering '*the weather gets you*', a sense in which the weather increased or diminished their capacities to exercise, which May echoed when she evaluated exercise as '*all right on nice days*'.

Although Tom and May, in common with the other participants, adopted wider discourses about the value and importance of exercise to health, they also positioned exercise as subordinate to the more important business of real life. The everydayness of the happenings that interrupt exercise indicated that exercise was incompatible with normal life, extraneous rather than routine. The statement that '*then life takes over*' reinforced notions of exercise as outside of normality, something less than real life. These discourses legitimized Tom and May's inability to maintain regular walks. In their double construction of exercise as valuable but impossible to incorporate into real life, Tom and May resisted lifestyle advice that presents such practices as simple and sustainable. They did not challenge assumptions about the value of exercise, however, and even as they constructed

exercise as short term and occasional, they still worked to maintain positions as responsible health citizens by attributing their failure to engage to forces beyond their control.

George and Susan also negotiated fluid, multiple realities of exercise, drawing not only on their embodied experiences of exercise as both pleasure and risk, but also upon other understandings of exercise in the context of having a 'lifestyle' disease. Willig (2009) draws attention to the logic of blame that underpins normative understandings of lifestyle diseases, according to which, people with CHD could be seen as failed health citizens (Tischner & Malson, 2012). From this perspective, the imperative to exercise has negative connotations as well as positive ones produced by discourses of exercise as empowering and responsible. The push-pull of these contradictory constructions contributed to the fluidity and transience of lifestyle behaviours. In the extract below, Susan oriented to their cardiac rehabilitation class as form of punishment:

Susan: yeah walking around and you wonder what you're doing there you know you're quite kind of (..) erm (..) me here and and then I started thinking oh it's (.) it's like we've been put in (..) it's like a prison yard you know when you see pictures of people walking around a square prison yard and they're having to exercise and it's all very a bit glum and nobody's talking very much and instructions are being shouted out and I was going to tell George and say and what did you do to be put here ((laughter)) you know it's like you have committed a crime you haven't you haven't lived your life properly you've haven't (.)

George: that's true

Susan: you've either smoked or you've ate the wrong diet or you're overweight or you you know you have to do a bit of exercise

George: you're a funny shape yeah

Susan: and so you're being punished and you're going around this square yard and so it was a bit like that (Int.1.ll.1053-1078).

Here Susan makes clear the moral dimension of lifestyle advice in her construction of the exercise class as punitive. Foucault's (1972) assertion that discourses are 'neither visible nor hidden' (p.109) is exemplified in Susan's dawning realization of this dimension of the experience. Initially, she did not see how she and

George were connected to a setting that is rehabilitative, but also punitive, ‘*you wonder what you’re doing here*’. She does not recognise herself and George as ill or culpable, but gradually she maps the power relations between those who have violated norms of health, health behaviour and appearance, those who shout instructions, and the unspecified others who pass judgement on health, appearance, and lifestyle behaviours (Wheatley, 2005). Susan’s vivid prison analogy echoed Foucault’s principles of governmentality: surveillance, normalization and hierarchical judgement (Foucault, 1980). Patients were in the class because of a failure to conform to norms of health and behaviour, which covered visibilities such as smoking and weight, and broader breaches, ‘*you haven’t lived your life properly*’, a form of medicalization and judgement of an individual’s everyday life which is characteristic of healthism and disciplinary power (Crawford, 1980, 2006). Susan drew on neoliberal constructions of health as a civic duty in her evocation of public sentencing and punishment, ‘*it’s like you’ve committed a crime*’, which also powerfully established personal responsibility and blame for health and illness. George highlighted the arbitrariness of this system, and hinted at forces beyond the control of the individual in his inclusion of ‘*you’re a funny shape*’, which may not be attributable to lifestyle, but which nonetheless comes under the gaze of normalizing, hierarchical judgment. Although this is not the only discourse of cardiac rehabilitation, as Susan and George demonstrated below, it was a powerful evocation of how neoliberal discourses of responsibility, blame and punishment are materialized in health practices such as the exercise class (Sparke, 2016; Wheatley, 2005). Susan constructed exercise here as stigmatizing and punitive, which built an account of exercise and lifestyle change as transitory, as, like a prison term, it would presumably come to an end.

Despite the negativity of their formulation of exercise, it did not exclude other, more affirmative experiences, as George and Susan went on to state, apparently paradoxically, that they both enjoyed and recognized the value of the rehabilitation class:

Susan: *we appreciated it*

George: *and we enjoyed it*

Susan: we actually enjoyed it and erm (.) (Int.1.ll.1083-1087)

The co-existence of both negative and positive evaluations of lifestyle change has implications for the sustainability of activities such as the exercise class. When asked whether they would continue to attend the classes after the end of the exercise programme, this ambiguity, multiplicity, and fluidity is reflected in their equivocal reply:

George: I think probably so um

Susan: yeah (.) oh yes I should imagine so I mean how [how long we

*George: [whether we
do it twice a week or*

Susan: um (.) um sense of gratefulness on your part to have come through it and the sense of um wanting to exercise parts of our body through repetition movements will carry us to further along the road I don't know (.) uh I I I'd like to think we do

George: mm

Susan: we would do it

George: it does get

Susan: yeah

George: a little boring (Int.2.ll.90-102)

In the context of negative formulations of exercise as punitive and boring and co-existing understandings of exercise as affirmative and curative, George and Susan negotiated their continued attendance. Hansen & Easthope (2007) argue that lifestyle change is necessarily future oriented, and in this extract, this future orientation encompassed hopes and fears that created ambivalence about the sustainability of their engagement in exercise. In their reflection on whether they would continue to attend, there was uncertainty in their hedging '*I think probably so*', and, '*I should imagine*'. In these imaginings, their future selves moved in and out of the gym as they spoke; they wavered between motivators such as gratitude, a sense of duty, the hope of greater physical capacities, and the demotivating admission that exercise regimes can be boring in the longer term. In her study of a cardiac rehabilitation clinic in the USA, Wheatley (2005) reports how, as for George and Susan, the

productive, affirmative experiences of cardiac rehabilitation coexisted with its disciplinary and sometimes oppressive dimensions. In Wheatley's study, the regulatory procedures of the clinic were disrupted by patients' resistance to organisation and surveillance, as their own desires and priorities are negotiated alongside the regime of the clinic, producing fluid positions and practices, as well as power relations. Despite their subjectification within the exercise class, Susan and George transformed disempowered subject positions in their mockery and criticism, and ultimately, in their freedom to not continue with the exercise.

Rather than decisions to adhere to lifestyle change depending on individual choice or self-regulation of 'imprudent living' (Doyle, 2001, p.30), the following interchange suggests that continued attendance was also contingent upon more relational and affective processes:

Susan: George has probably got a better um

George: yeah whether I'd do it without you [I don't know

Susan: [commitment than I have

Int: does it you feel like it helps though

George: what that she comes along

Int: yeah

George: absolutely

Susan: yeah so I will no if George feels he he he'll sustain it and that'll encourage me then yeah and it structures the week (Int.2.ll.204-234)

Lifestyle advice is predicated on permanence and maintenance of healthy behaviours, but despite George and Susan's recognition of the importance and value of their exercise classes, they negotiated their continued attendance in more ambivalent ways. They constructed their future health practices as interdependent, and the other person as essential to their continuance with the exercise class. Susan made a statement about George's greater commitment while simultaneously, George attributed his attendance to Susan's support. In response to his affirmation of Susan's support, she resolved more firmly '*so I will*', though she followed this with a caveat '*if George feels he he he'll sustain it*'. The interdependence continued when she

stated that George's commitment 'will encourage me', as they produced interweaving, relational durations of recovery, rehabilitation and exercise as a potential part of their future lifestyle.

Reciprocity and interdependence could support couples' adherence to lifestyle change, but also to undermine their efforts. Richard (a businessman in his late 60s) recounted his and his wife's attempts to regulate their crisp eating:

Richard: last night's a classic example you see she said we have we have crisps and nuts as most households do when we have guests you know have a drink and a few nuts and crisps around the place so 'I just fancied a crisp' I said 'no no you mustn't have them' and the minute I said 'no' psheew out they come it's one of these big Kettle things you know we had to throw it into the kitchen to to stop ourselves eating it 'cause I took you know a handful stuck it inside and said that's my portion control you know maybe we can eat like this and then I had another lot I said put them away ha

Int: so why do you think when you said no we mustn't what happened there that didn't work

Richard: it's again indulgence or well my wife is is is contrary so if you say no then I think I'm contrary as well (...) yeah yeah if I said let's have some more she wouldn't instantly psheew throw them away I say don't have some more she'll have some more that's isn't that human nature ish (Int.2, ll.912-961)

Deleuze's concept of assemblage provides a framework for mapping the complexity and uniqueness of sets of relations. Deleuze argued that what we desire is always an assemblage, never a single or simple object, never just a glass of wine, but always a particular wine in a particular setting and company (Deleuze & Parnet, 1988). Moreover, he stated that we always desire from within an assemblage, which accounts for the enormous complexity of even apparently simple activities and interactions. The concept of assemblages accounts for the multiplicity of relations and affects between material and non-material components, and for variability over time and space (Deleuze & Guattari, 1987). The same people behave quite differently on different occasions within the same setting, or in different setting, sometimes accepting, sometimes rejecting an 'unhealthy' treat such as the crisps in this extract. From a Deleuzian perspective, the crisps are part of an assemblage, not just an inert, neutral item of food, but connected with time, place, and people, and

productive of embodied, affective, embedded experiences. Understandings of crisps as delicious, desirable, but unhealthy forms an assemblage comprising of scientific evidence, situated in a time of alarm over an ‘obesity epidemic’, understandings of food as the cause of and cure for diseases, contemporary marketing campaigns, availability and price, and the embodied, sensory experience of eating them. Richard located the crisps in this way, as part of their social life, offered to guests and accompanied by alcohol, and as a delicious, but problematic, treat that he and his wife share as part of their relaxation and enjoyment in the evening. There was a push-pull between the crisps as risky and the normative expectation that you provide them for guests and share them as a couple.

Richard attempted to account for the experience by drawing on neoliberal notions of risk, self-regulation, and rationality in his aspirations to ‘*eat like this*’, and manage their intake of unhealthy food. According to neoliberal logic, he positioned his wife and himself as ‘*contrary*’ in the light of their failure to conform to these norms. He softened this designation by normalising their behaviour, as they had crisps in their home ‘*as most households do*’, and re-ascribing their failure to ‘*human nature*’ rather than personal qualities. Elsewhere in his interviews, Richard claimed to have knowledge about nutrition, and expressed the expectation that he should therefore be able to control behaviours. But the experience clearly exceeded his ability to account for it, as even a brief consideration of food as an assemblage indicates the immense complexity of eating behaviour, that cannot be reduced to a cognitive and morally weighted decision to eat or abstain from crisps, behaviour that further gains in variability and unpredictability within the context of an intimate relationship.

Participants constructed lifestyle change as fluid and ephemeral. Deleuze’s concept of dynamic assemblages and multiplicity accounts for the fluidity, apparent contradictions and inconsistencies that are traceable in couples’ talk about health. Couples positioned themselves discursively in relation to norms of health and relationships, but their experiences were also emotional, embodied, unfixed and unfolding. In some cases, material elements of assemblages of health and lifestyle, such as the weather, the interdependence of couples’ health practices, the unstable subjectifications and affective experiences of the rehabilitation class, and the

changeable, contingent nature of couples' shared eating habits all contribute to lifestyle as a complex, unpredictable, and ever changing. Couples negotiated these complexities in the context of public health campaigns that construct lifestyle change as simple to achieve and maintain. As I set out below, for the participants in Study 2, their illness and recovery and lifespan formed distinct time frames in their management of lifestyle change.

9.2 Temporal Selves: Plural Timeframes of Recovery.

Couples' referred to multiple time-frames or durations of recovery, ageing and other disease processes and diagnoses which co-existed in dynamic relation to each other, and facilitated management, acceptance, stoicism, and the assertion of values other than the narrow pursuit of health through healthy lifestyle. Participants recounted several ways that fluid experiences of illness, recovery and health were negotiated within long-term relationships, as partners sometimes had differing understandings of processes of recovery and return to pre-diagnosis physical and psychological functioning.

For Deb and Jack (retired skilled workers, late-60s), exercise and physical exertion gained new and negative connotations which were negotiated alongside pre-existing, more positive understandings and experiences. They recounted that they used to enjoy long country walks prior to Jack's diagnosis. They both attended Jack's cardiac rehabilitation class, but they problematized a return to their daily walks, and contrasted their anxieties about independent exercise with the security they felt in the classes:

Deb: yeah and it's nice to have the opportunity to do that

Jack: really helpful like because with (.) when we sort of erm after got back home didn't I (.) we sort of they say when you you know you should walk and that but round here there's it's all hills and a lot of hills you know it's difficult to find and then you go out and you start coming up hill and (.) you don't know whether you're doing more harm than good (.) you know you you you're quite frightened to push yourself cause you think well am I am I sort of risking another heart attack or not like 'cause when you go to the rehab (.) it's controlled like so you're not afraid of sort of doing damage you know

Int: *yes 'cause*

Jack: *I think that really (.) very er I think without that it would be very difficult (Int.1.ll.202-220)*

Jack emphasized the difficulties, embodied and emotional, of fulfilling imperatives to exercise, and constructed a separation between the 'should' of common understandings of the importance of exercise, and the problematic, risky actuality of exercising after a diagnosis with CHD. Just as the weather was an impediment for Tom and May, the unalterable geography posed physical and emotional challenges for Jack and Deb, constructed through his extreme-case formulations and repetitions of '*all hills and a lot of hills*'. The hills transformed the benefits of exercise into risks, potentially '*doing more harm than good*'. Jack experienced a strong, negative emotion when confronted with hills, which formed a physical boundary to his capacities, powers and recovery. Jack was cutting trees in his garden when he experienced his first cardiac event, and his expression of his fear that physical exertion might cause another, established a causal connection between exercise and CHD, a belief that co-existed with other understanding of exercise as beneficial.

For Jack, outdoor exercise had become risky, and he constructed a lack of control in independent exercise through his evocation of fear and risk of harm, and his designation of the rehabilitation class as '*controlled*' as well as place of safety, where '*you're not afraid of doing damage*'. The control is provided by the presence of health care professionals, whose expertise and support contrasted with his and Deb's fearful response to the prospect of resuming their previous walks in the countryside:

Jack: *and you're a bit remote there*

Deb: *you don't normally see anybody do you*

Jack: *sometimes we go miles and we don't see another person (Int.1.ll.506-510)*

Jack and Deb stated that they would feel at risk on what used to be a frequent, easy walk. The fear that Jack would have another cardiac event changed their evaluation of their previously enjoyable exercise, and their emphasis on the

remoteness and emptiness of the landscape constructed it as a site of isolation and risk rather than of pleasure and relaxation. Jack's fears about exercise were shared by Deb in their joint endeavour of health, and she also shared his sense of reassurance in the exercise class:

Deb: yeah and I think it's good that they say like cause I go with him and I do it as well and I think that's good and I think it's it's a good idea that the partner does go along and see what's happening and er I think it helps that does really yeah (..) cause it is like you say it's it's not only Jack it's affected it's me as well you know erm and I I think probably (..) I'm worse if he's doing anything you know and I say oh (..) mind what you're doing I think probably a bit over protective even though I'm like trying to sort of (..) you know stand back and and say well

Jack: you know I don't want to become

Deb: he knows

Jack: become an invalid that's the last thing I want

Deb: no no

Jack: you know (..) I want to get back to so

Deb: so (..) sort of this past week certainly I've let him you know if he feels as though he wants to do with you know (..) I mean he's not gone out chopping any trees down or anything or cutting hedges like he was

Jack: that's what brought it on in the first place (Int.1.ll.202-253)

The joint exercise in class, and her experience of seeing Jack exercising safely was reassuring for Deb, as she negotiated her own as well as Jack's fears. She balanced fears of his over-exertion against the risk of her overprotectiveness producing other problematic identity outcomes. They sketched a fearful future, where their joint anxiety might limit Jack's capacities, and they both resisted a dispreferred identity as '*an invalid*' as '*the last thing I want*'. Although Jack had a past level of activity that he wanted to return to, those activities were linked to his cardiac event, '*that's what brought it on in the first place*', extending the risk of exercise from the past into the future.

For Jack and Deb, his diagnosis with CHD created multiplicity; it was both a motivation to exercise and a reason not to. Physical exertion was a desired goal, a

‘normal’ that he wanted to return to, but also a source of anxiety that they both negotiated. This extract illustrates the multiple realities of exercise and time; exercise was a source of pleasure, a measure of health, functioning, and recovery, but also the ‘cause’ of his cardiac event. Jack and Deb moved fluidly between these different understandings of exercise, their past capacities, and fears and hopes for the future. In contrast to conceptualisations of recovery and resumption of exercise as linear and progressive, Deb and Jack’s account was full of ambivalence, contradictory positions, accepted and restricted practices of exercise, and the negative as well as positive emotions connected with those practices.

Temporalities of recovery and aging could also be more affirmative, though these affirmative constructions were complicated by parallel discourses and occasionally by a partner’s divergent understandings of exercise and recovery. Carl, for example, had been extremely active throughout his life; he cycled, walked, and worked on his house and garden, and had even been ‘told off’ for over-exerting himself in the cardiac rehabilitation class. In the following extract, Carl reflected on his recovery, fitness, and health, drawing on his past, present, as well as his hopes for the future:

Carl: well I the concern is you (..) there doesn't seem to be an end stop on what you can do er (..) for me er erm and so there is a danger you've still got old age there there is a danger you can (..) over do it which I would probably be guilty of lots of stuff but erm (...) er that that's the only thing you you you do have to remember you're 65 or whatever it is and er (..) but er you know (..) generally speaking I've got er so much more energy than I ever well probably ever had

Int: really

Carl: I was gonna say or should I say ever can remember ((laughs)) that's probably nearer the mark I I don't feel I've lost anything from when I was young er that's how it is (..) er you feel as though you've got a new engine unburstable and er off you go you know see what happens (...) on the negative side (..) I I do still feel tired sometimes or quite quite I'll say quite often you know erm but that probably is the old age thing recovery takes longer when you're older and as you will find out ((Laughter))
(Int.2.ll.223-235)

Carl talked about old age and its capacities in fluid and apparently contradictory ways, oscillating between affirmative affects of increased powers, in which his physical capabilities had not diminished from his youth, to more conventional discourses of old age as marked by risks and deficits. He began with an affirmative statement of the fluid possibilities of old age echoing Deleuze's sense of the body's possibilities and powers '*there doesn't seem to be an end stop to what you can do*'. But after this statement he equates old age with risk, in his repetition of the '*danger*' of over-exertion. His drawing on a normative, moral framework to such overdoing, '*I would probably be guilty of*', reinforced the boundaries of age-appropriate behaviour that he contravened in the exercise class. He then immediately contradicted such age-related norms when he asserted that his energy levels exceeded those of his youth, which was counterbalanced with his joke about his memory, which again asserted a more stereotypical association of old age with deficit. Switching back to his more affirmative standpoint Carl repeated his claim to have experienced no decline in his physical powers, with his striking, powerful construction of his mended heart as an '*unburstable engine*'. This claim to increased capacities thus troubled notions of time and the ageing processes as linear and tending towards deficit and loss. But Carl follows this with a statement about his concurrent, embodied experience of tiredness, which he normalized in his attribution of tiredness to '*the old age thing*'.

Carl's switching between co-existing realities that would usually be considered conflicting or mutually exclusive was a common pattern in his interview data. His experience of ageing encompassed a chronological age in his mid-60s, but a sense that his capacities were the same as a younger man, a dissonance he bridged by asserting that old age is a time when powers can be undiminished, and that he still possessed the physical capacities of his youth. Bergson and Deleuze's theories of time offer a resolution for these apparently contradictory experiences and constructions. They proposed that time can be thought of as the unfolding of subjective experience. The multiplicity of experience therefore produces distinct '*durations*' that co-exist, a fluidity that people then negotiate, as Carl demonstrated.

The temporal and discursive fluidity of Carl's account has implications for his relationship. He constructed his exercise as a means to and measure of recovery

from his CHD, which diverged from Elsa's expectations of aging and recovery. In the extract below, Elsa expressed a high level of concern about Carl's physical exertion:

Elsa: but the thing is erm (...) the way I see it with him is he skips he still keep whining oh you know he's lots there's lots he wants to do he hasn't done I said yes but I said now you should be grateful that you have enjoyed doing lots of things you know you have had a healthy youth and things like that

Carl: yeah but I haven't reached the age where I I want to stop (Int.3.II.1187-1195)

Elsa: if you (.) overdo it you will have a stroke and if you do have a stroke you know (.) as you say your mum had a stroke (.) what's happened (.) she lost her speech you know and things like that that's what I'm trying to say overstressing your body (Int.3.1346-1352)

Elsa attributed appropriate behaviours to different stages of life, based on a linear, unitary model of time. She advocated acceptance of changing capacities with the passage of time, and problematised Carl's refusal to accept the aging process. There was a moral dimension to her evaluation of his behaviour, with an implication of unreasonableness and immaturity in her use of 'whining'. Despite Carl's earlier designation of himself as old, he resisted normative discourses of acceptance of decline and gratitude for past health that Elsa offered, and was not able to reconcile his age with his desires to keep pushing the boundaries of his capacities, 'it's not the age where I I want to stop'. For Carl, this energy was affirmative, but it evoked anxiety in Elsa, and produced conflict in their relationship. During the interview, the section of talk where Elsa expressed her fear that he would have a stroke was heated, and she was angry and distressed at the prospect that his high level of activity, together with his high blood pressure and his family history could damage his health. The imperative to exercise as part of his CHD treatment and recovery co-existed and conflicted with other norms and the expectations of his partner. For Elsa, the past and future was brought into the present. Carl was currently a person who had done a lot and was also a person with a genetic risk of heart disease (based on family and his own recent diagnosis with CHD). Her future orientation was focused on managing that risk, while Carl also managed the identity risk of being a person who

has '*stopped*'. His present and future selves needed to still be doing, and be as vigorous as the past self, to be valid.

Participants constructed health as a moving horizon in their recovery from their diagnosis and treatment of CHD. They drew on multiple temporalities in their accounts, constructing past experiences and capacities as affecting their present functioning and future hopes. The joint endeavour of couples' health compounded this complexity, as participants negotiated the fluidity of their own and their partner's experiences and expectations of recovery, lifestyle and health. Couples experienced conflict, tension and anxiety over exercise and eating, but in the following section I explore the ways in which they talked about temporalities relating to lifespan and death, which produced alternative discourses and some affirmative transformations.

9.3 Death Comes to Us All.

As Crawford (2006) predicted, a focus on health is likely to bring about a greater sense of jeopardy, with references to illness and death in health promotion confined to fear-evoking warnings (Lupton, 2014; Petersen & Wilkinson, 2008). In dominant health discourses, death is the antithesis of life, the endpoint against which people struggle, which creates fearful, deficit discourses of aging and death. But the participants in Study Two oriented to death in multiple ways. Their diagnoses of heart disease brought awareness of mortality, and they acknowledged fear and distress. But death was also constructed in affirmative ways, offering a perspective on life, issues and problems (including those relating to lifestyle change), wisdom and acceptance. For Deleuze, death 'is coextensive with life...living is inseparable from the partial deaths that it goes through' (Colombat, 1996, p.241). Death is part of life, not its opposite, since even when we die, 'one is nonetheless affirmed as an individual' (p. 242), and in life, because it is always ahead of us, it is 'a virtual that never gets accomplished – we are always in the process of but never complete dying...essential to the creation and proliferation of life and thought' (Colombat, 1996, p.242). This concept of death afforded a mapping the creative and affirmative evocations of death in participants' accounts, such as when awareness of death was used to warrant a zest for living, and a hedonistic rather than a puritan way

of life, as in the extract below from George and Susan (mid 60s, retired public service workers):

- George: *yeah I'm happy to do moderation I'm not happy to cut things out (..) I'm still not happy about those absent fried breakfasts I mean we'll occasionally have them*
- Susan: *yeah occasionally*
- George: *we stayed in one of these Premier Hotels*
- Susan: *oh gosh and tuck into them like there's you know no tomorrow*
- George: *eat as much as you like breakfast ...*
- Susan: *oh a real treat yeah and that's it it's moderation*
- George: *I know I won't cut it out completely I'm not going to be a puritan about it I don't see the point because it's something in life I actually enjoy and I mean if it has to be written on his tombstone you know he continued to eat the occasional fried breakfast [laughter] then I'll settle for that but I'm not going to ((laughing)) (..) I don't care that's fine erm (...) having survived this long (...) you know (...) (ll.1619-1661)*

In this extract, shifting temporalities afforded different and contradictory constructions and practices of dietary management. Initially, George adopted the discourse of moderating rather than eliminating unhealthy items from one's diet, but immediately qualified his statement that he's '*happy to do moderation*', when he expressed his unhappiness at the deprivation of the '*absent fried breakfasts*'. They were still desired, and their absence was fluid; they were still indulged in '*occasionally*'. Susan and George vividly evoked the pleasure they both took in the breakfasts through their emotive exclamations '*oh gosh*' and '*oh a real treat*'. The temporality that allowed such abandonment of restraint was a present disconnected from future consequences, '*tuck into them like there's you know no tomorrow*'. This hedonism was a temporary line of flight away from dominant understandings of certain foods as risky and in need of control, but it was soon fenced in with time-related modifiers, '*occasionally*' and '*it's moderation*' in a reassertion of neoliberal values of self-discipline and lifestyle management. But George also referred to his future death, what will be '*written on his gravestone*', to provide a perspective on the self-denial of the present. In a cost-benefit analysis, George came down on the side

of hedonism and pleasure, an acceptance of risk, and freedom if not from judgement, at least from anxiety about such a judgement, *'I'll settle for that...I don't care'*.

Death was also invoked in ways that afforded peace of mind amid the anxieties of ill-health. As discussed in Chapter 7, Deleuze imagined such serenity, as a 'third axis' that coexists with power and knowledge and which allows a resolution, however brief, of their impasses and power relations, 'the place where a sense of serenity would finally be attained and life truly affirmed' (Deleuze, 2006, p.80). At points, some participants appeared to access such serenity and acceptance, as in the extract below, where Louise deterritorialised the limitations and unfulfilled promise of health injunctions and discourses:

Louise: yeah I always yell at my husband about you need to eat three times a day you need to exercise at least three times a week you need to go to bed at a regular hour you need to get up at a regular hour you need to take care of yourself (.) and then who winds up with a heart attack and so it's like what did I do and the first thing I started to cry the other day when I was with [nurse] and I said what did I do wrong she says you didn't do anything wrong she says Louise if this is genetics you did nothing it just happened just like it's you know trees get leaves trees lose leaves trees get leaves trees lose leaves one branch might grow bigger than the other branch it's part of the tree and and it's the same thing with me and as long as I can stay on top of that thought I'm okay (Int.1.ll.447-460)

Louise's extract started with her as someone who bought into linear, causal relationship between lifestyle and CHD. She had imposed all the 'rules' on herself and her husband, so her illness left her questioning an understanding of disease that positioned her as responsible and culpable. In her adoption of the tenets of healthy living, she could not get outside of the discourse, and was trapped in the painful logic of causality and culpability, *'I started to cry ... why did I do wrong?'*. The nurse's reassurance offered her an alternative conceptualisation of health and illness that constructed them as cyclical, natural, unpredictable and uncontrollable. When she equated herself with trees that gain and lose leaves, her illness, and by implication, her eventual death, became inevitable, a natural phenomenon, removed from the distress of causality or blame. Louise's peace of mind was fragile, lasting only *'as long as I can stay on top of that thought'*, but however briefly, this

acceptance of natural, cyclical processes and her lack of agency in them calmed her guilt and anxiety, and produced a serene perspective on life.

This shift from linear to cyclical understandings of time thus created an empowering acceptance for some participants. However, there was also the potential for one partner's acceptance to run counter to or be threatened by the other's health anxieties and practices. Where couples took different positions in relation to discourses of control, autonomy and fatalism, they negotiated apparently mutually exclusive discourses of acceptance and agency in relation to healthy lifestyle, exemplified in the interaction below between George and Susan:

George: but you see it's a different philosophy of life

Susan: yeah it is

George: because it's like you know you have the concern about food and you take a lot of trouble over it and you had the concern about my smoking

Susan: yeah

George: and (.) I tend to think your name's on the bullet or it's not and there's nothing you can do about it erm (..) although of course there are things you can do about it (Int.1.ll.231-244)

Susan and George's divergent positions warranted engagement and non-engagement in lifestyle change respectively, as she adopted dominant, expert discourses of lifestyle management, and he took up a more fatalistic position. He attributed Susan's position and practices to relationship norms of care and concern. His three-part list emphasised her concern for him, and the related practices and hard work in a positive light, '*you take a lot of trouble*'. The logic of George's position that either '*your name's on the bullet or it's not*' was that no amount of action on his part would influence the trajectory of his illness, and legitimised the difference between Susan's approach to healthy lifestyle and his own more laissez-faire practices. He can also be seen as recognising and accepting uncertainty, and perhaps attaining some serenity in relation to his health and life. As a partner in a long-term relationship, he negotiated his partner's as well as his own understandings, and in line with norms of congruity, harmony and compatibility, worked to encompass and validate Susan's as well as his own approach.

Participants built accounts of experiences that are both multiple and dynamic, expressed in terms of fluidity and coexistence of apparently conflicting discourses. George juxtaposes both fatalistic and agentic understandings of healthy lifestyle. His words appear logically inconsistent, as internal and external loci of control are mutually exclusive in health psychology. Indeed, although George does retreat from the extreme formulation of *'there's nothing you can do'* with his immediate contradiction *'although of course there are things you can do'*, he articulated multiple, parallel and competing discourses where fatalism and control exist simultaneously. Here, George seemed to agree to differ from Susan, but couples' health practices can encompass joint processes of acceptance of changes over time and death, as the examples below illustrate.

For Holly and Graham, acceptance and serenity was part of their joint endeavour. In chapter 7, Holly achieved her release from anxiety and depression with help from Graham. In the extract below, Holly rejected the neoliberal premise of control and agency, asserting a different set of values in relation to health anxieties. For her, it was the inevitability of death that provided a perspective on illusions of control:

Holly: I think that's where people go wrong they do it because they're able to do it and they think that they can conquer the world (.) you know you can't you can't change the world you can't conquer it so let it get on with it and that's the way I feel about it (.)you're going to be in a wooden box sooner rather than sooner (.) than you think if you keep worrying and stressing yourself out

Int: right right

Holly: and I I do think (.) that people don't realise the amount of damage stress does to your body you don't do it I don't do it (.) and (..) I'd rather (.) I'd rather chill (Int. 1, ll.1384-1393)

Holly constructed control as a fruitless endeavour, with her three-part list of impossibility, *'they think they can conquer the world (.) you know you can't you can't change the world you can't conquer'*. She equated control over one's own life with controlling the world, constructing both as equally extreme, impossible, and unreasonable. Health promotion evokes a fear of death as a means of controlling health behaviours (Lupton, 2014), but offers no normalisation of physical decline

and death. For Deleuze, death can never be fully realized, because it is always ahead of one. In line with this notion of the co-extension of death with life, and in common with many of the participants, Holly talked comfortably about death, *'you're going to be in a wooden box sooner'*, including it in her analysis of the costs of anxiety.

Holly drew on an understanding of health anxiety as self-defeating. She echoed Berlant's (2011) notion of cruel optimism, whereby the means to achieving a desired end or object becomes a barrier to its fulfilment, when she predicted that death would come *'sooner (.) than you think if you keep worrying and stressing yourself out'*. Holly and Graham claimed that an essential part of their psychological and physical health was an acceptance of their uncertain, risky future which enabled them to access serenity and an affirmation of life freed from the constraints and anxieties inherent in healthism.

The participants' talk about health also indicated more ineffable ways in which they affected and were affected by each other, the fluidity of time within processes of lifestyle change, and the attainment of acceptance of processes of aging as well as of recovery, exemplified in Catherine and Henry's interactions across their interviews, which included patterns of ambivalence around Henry's increasing vitality. MacLean et al. (2014) report an unexpected finding that some women were ambivalent about their male partner's weight loss, anxious that their newly slim and fit partner might be attracted by or attractive to other women. Such multiplicity and unpredictability in couples' health interactions were also present in Study 2 data. During their three interviews, Catherine and Henry's interactions appeared gentle and supportive. Catherine was intimately involved in Henry's health, and monitored and managed his dietary changes, though she had limited mobility and was unable to take part in his exercise classes. As he recovered, though, and talked about his improving fitness, Catherine repeatedly responded with talk about her past as an athlete and sports coach, and emphasised Henry's lack of physical capacity or sporting prowess. Here Henry was talking about his exercise class, which he enjoyed and felt was benefiting his health:

Henry: *I just get a a a bit of a sweat on so it's obviously doing some good*

Catherine: I find Henry gets tireder now he he's slowed down quite a bit to when I first er worked with him years ago (Int.3.ll.118-120).

Henry equated physical exertion with improving health in his vivid evocation of his strength and physicality as he worked up a sweat during exercise. Catherine countered Henry's positive, embodied experience with a claim about his tiredness and physical decline in comparison with his past physical capacities. In talking about when she 'worked with him' she referred to her own past as a sports coach, invoking her strength and equality when she 'worked with' him. Assemblages are made up of virtual as well as actual components, exemplified in the drawing out of a virtual self in Catherine's affective response. The self who cannot take part in the exercise class coexisted with the powerful athlete and teacher, superior to Henry in her own field. Henry and Catherine's interchanges indicated the unpredictable, multiple affective flows within the assemblage of Henry's health. He was at once the patient who had a life-threatening cardiac event, necessitating dietary change and caution with physical activity which Catherine anxiously monitored, but also the attender of cardiac rehabilitation and gym classes which had opened up new capacities for him. His exercise regime highlighted and widened the gap between their relative physicality; he was clearly fitter than her now, and his engagement in cardiac rehabilitation illuminated deficits and differences as well as new strengths and possibilities, which they had to negotiate. Catherine oriented to his physical strength as a troubling disparity in their physical capacities, a gap which she worked to equalize or diminish by bringing the past into the present.

In their last interview, however, there was a break in the pattern of Catherine's affective responses to talk of Henry's physicality. Catherine recounted a recent family walk to a nearby beach and hill. Henry and the younger members of the family climbed the hill, and Catherine made her first acknowledgement of Henry's recovery and regained capacities:

Catherine: we went went down on our favourite all of our favourite the whole family er always used to go to [the beach] and the younger ones erm Henry walked up the top you know and erm (.) onto the beach er (.) and he managed ok didn't you (Int.3.ll.522).

Her account of Henry's successful climb positioned him with the 'younger ones', but despite this categorisation, her use of 'all', 'whole family' and 'we' created a sense of unity and togetherness. With this acceptance of his recovery, Catherine also acknowledged her own more limited capacities:

Catherine: I used to go up there I don't go up there now [...] yeah we the rest of us the old crocks down at the bottom sat there waving and they were waving back you know (.) (Int.3.ll.545-558)

The emotions implicit in and evoked by Catherine's positioning of herself among the 'old crocks' at the bottom of the hill, waving to the younger and fitter members of the family were fluid and multiple. There was both a poignant sense of loss, but also of acceptance of changing times and capacities in the balance of 'I used to go up there I don't go up there now', and the disdainful but also humorous designation of herself and siblings as 'old crocks'. The space between the younger and older people was bridged by affection and communication, as Catherine 'sat there waving and they were waving back', her use of 'you know' signalling the normativity of the state of affairs. This extract is illustrative of the multiplicity and complexity of such embodied, affective, embedded experiences and temporalities that were present across the data in this thesis, and which resisted clear categorisations and evaluations.

9.4 Discussion.

Time as unitary and linear is taken for granted in biomedical and health psychology literature relating to lifestyle change and recovery from CHD. There is very little engagement with time as a factor in couples' health practices, apart from Radley (1996). But time was very salient in both studies, and was constructed in a range of ways that have implications for couples' management of lifestyle change. Despite discourses of lifestyle change as stable and enduring, couples' accounts constructed lifestyle change and behaviour as fluid, uncertain, and unsustainable, recovery and health as a moving horizon, and also drew on a discourse of acceptance of time, change and death. Couples position themselves in relation to wider discourses that value agency, self-regulation and control in the achievement of stable states of health, but also have to negotiate each other's understandings of time in relation to recovery, resumption of previous activities, and future risk. Partner's

anxiety and over-anxiety about a spouse's health after a diagnosis of CHD is common in the literature (e.g. Smith, Hart, & Cupples, 2012), but framing the problem as a difference in perceptions of time-frames and durations of illness and recovery focuses attention on ways in which partners might be reassured or reach a compromise over their expectations, locating the issue externally rather than attributing it to flaws in individual or relationship functioning.

Fluidity is a further ontological and epistemological gap that couples negotiate in their co-management of lifestyle change. This fluidity requires a conceptual framework that accounts for the co-existence of multiplicity and fluidity in the couples' accounts. Barad (2003) writes that 'the qualities of matter are so many stable views that we take of its instability' (p.80). In contrast to health discourses that promote health as simple, achievable, and sustainable through rationally chosen lifestyle behaviours that achieve a stable state, couples in this study negotiate healthy living as fluid, effortful and ultimately, short term. An inability to maintain diets or exercise regimes can evoke blame, guilt, and frustration as partners perceive this as a failure which reflects on their own identity as well as their functioning as a couple. Stronge (2012) argues that medicine, with its diagnoses and treatments as well as its expert knowledge which is held to be stable and universal, emphasises linear views of time and stable states of illness and health. This is reflected in health promotion and advice, which only uses death as a fearful object in the management of risk. Participants' talk about time – recovery, sustainability of healthy lifestyle practices, lifespan and death, reveals a temporal multiplicity and fluidity, which participants negotiate alongside more conventional understanding of time as unitary and linear. This fluidity requires a conceptual framework that accounts for the co-existence of multiplicity and fluidity in the couples' accounts that cognitive models of health belief do not encompass.

Health advice suggests that lifestyle change is easy to institute and to maintain. Peoples' inability to achieve stable healthy lifestyle is understood as irrational, a failure to properly evaluate risk, or to exert appropriate self-control. Lifestyle changes and goals such as improving one's diet, exercising, and weight loss are recognised to be short term, even in cases where a diagnosis such as diabetes or heart disease might be expected to motivate patients to make permanent changes.

Dominant understandings of time as unitary and linear contribute to discourses of stability in health and lifestyle, and are also involved in understandings of agency and fatalism. In this study, couples' talk about time involved complex and multiple time frames. Participants referred to the trajectory of their recovery as a finite period that would return them to a past state of health and function. Simultaneously, they locate themselves on a lifespan in which older age brings a seemingly inevitable decline in health and capacities. Furthermore, despite the absence of death in lifestyle advice and information (except to underline the seriousness of the risks posed by a poor lifestyle), participants frequently invoked death as part of their talk of time. These elements interact in complex ways. The recovery period was constructed as a time for and motivation for change. Talk about exercising and managing diet construct the participants as agentic and responsible, but understandings of ageing and inevitable change also legitimized a more fatalistic approach. If loss of function and death are unavoidable, then the efforts to maintain a healthy lifestyle are also ultimately doomed or futile. On first consideration, time may not appear to be a factor that directly affects health behaviours, but in their accounts, participants anticipate future benefits as well as losses. Repetition can be experienced affirmatively in valued routines, or as sterile and 'boring', as Susan and George contemplate their future exercise classes.

Death provides a perspective on life, a philosophical standpoint from which excessive concern about the minutiae of daily life – what is eaten, done or smoked, appears trivial. Other positions and practices become more valued from this viewpoint. Acceptance, resignation, and hedonism are all put forward as appropriate responses to the contemplation of death, all of which may work against a conscientious adherence to lifestyle change and rigorously healthy living. Bergson's theory of time as subjective and multiple accounts for the complexity of the different durations that make up participants' experiences of recovery and health, and the interactions and subjective experiences of these different time frames, resolves some apparently irreconcilable contradictions. Carl's future heart is 'unburstable' at the same time that he acknowledges reduced vigour with age. George is agentic in terms of his post-MI exercise regime, but also fatalistic about his health. The ways in which participants move between past, present and future, and different durations,

affords them particular positions, warrants practices, and shapes subjectivities. Mapping Deleuze's conceptualisation of existence as a process of becoming rather than stable states of being onto participants' experiences of time, reveals multiple, co-existing and distinct realities of disease 'are different versions, different performances, different realities that co-exist in the present' (Mol, 1999, p.79), which 'trade places, blur, slide into one another, and occasionally come into conflict in an unending and fluid process' (Stronge, 2012).

Time formed a distinct discourse in the couples' accounts which they negotiated, along with their understandings of health and healthy living as a joint endeavour, and of lifestyle as a form of risk management. These interconnecting discourses produced considerable complexity in the context of pervasive lifestyle advice and/or experience of a lifestyle disease. Adding to the unpredictability of couples' health practices were intricate patterns of adoption, resistance and transformation, as couples took lines of flight away from dominant discourses of health and understandings of risk and time. Continuous affective processes produced ways of being that could be seen as sometimes negative and undermining of mental and physical health, but sometimes positive and life affirming.

Chapter 10: Discussion

In this chapter, I present the aims of the study, and then discuss the key novel findings of Study 1 and 2 in relation to the aims and research questions of the thesis. I then examine how these findings map onto and build upon existing health psychology and critical health literature. I consider the implications of the findings, present a reflection on both studies, and discuss directions for future research.

10.1 Aims of the Study

The first aim of the thesis was to address an important gap in the literature on how couples make sense of lifestyle advice. I therefore conducted an in-depth exploration of how both healthy couples and those affected by lifestyle disease (using CHD as an example) talked about and managed lifestyle advice. The analysis focused on how lifestyle advice was adopted, resisted, or otherwise negotiated in couples' shared lives and health practices.

The second aim of the thesis was to develop a theoretical framework that could account for couples' sense making and practices in terms of engagement and non-engagement in lifestyle change. The existing mainstream quantitative and qualitative literature indicated considerable complexity in couples' health interactions and pointed to the potential for negative as well as positive health outcomes. Relationship quality and style, social support, and style of health interactions and communication were all implicated in previous research on couples' health behaviours, but no one theory or perspective encompassed the variability and dynamism of psychological, social, interpersonal, and physiological factors within intimate relationships.

Further, I argued that past health research often had the potential to contribute to the problematisation and stigmatisation of health behaviours and intimate relationships. Thus, there was a need for a framework that could avoid stigmatisation to engage more ethically with the challenges participants might face when negotiating health in relationships. I also argued that, in its analysis of power, critical health research tends to focus upon its negative ramifications rather than productive

potential, and so the second aim of this thesis was to develop a theoretical framework that reached beyond notions of dysfunction to explore the complexity of health negotiations in couples in an affirmative way.

Arguing that research on negotiating lifestyle advice needed to include the context of powerful and pervasive social discourses of healthy lifestyle and of intimate relationships, the thesis started with a critical, discursive approach to examine how dominant understandings of healthy lifestyle shape couples' subjectivities, emotions, and practices. But, responding to aspects of the data that were not captured by this Foucauldian framework, I sought to develop the approach by drawing on Deleuzian concepts, as well as the ontology developed by Deleuze and his collaborator Guattari. The framework proposed to meet aim two was thus a novel Foucauldian-Deleuzian approach developed through a poststructuralist standpoint and subsequent data analysis.

The two aims of the thesis were therefore firstly to offer an in-depth analysis of how lifestyle advice is adopted, resisted, or otherwise negotiated in couples' shared lives and health practices, and secondly to develop a theoretical framework that accounts for the complexity of health negotiations in couples in an affirmative way. I discuss the findings of the study in relation to these two aims and the two research questions. The first asks how people in long-term relationships talk about and manage health, lifestyle and lifestyle change advice in both health and illness (using CHD as an example). The second questions whether a Foucauldian-Deleuzian theoretical framework accounts for and offers new perspectives on the variability and complexity of health behaviour within long-term relationships.

10.2 Key Findings Research Question 1

The thesis offered four key novel findings when addressing the first research question: How do people in long-term relationships talk about and manage health, lifestyle and lifestyle change advice in both health and illness (using CHD as an example)? These findings are outlined below:

Joint technologies of the self: Despite the strongly individualistic focus of lifestyle advice and information, couples universally constructed health and healthy

lifestyle as a joint endeavour. To conceptualise this finding, I expanded Foucault's (1988) notion of individualistic technologies of the self to encompass couples' work on their partner's as well as their own appearance, weight, and lifestyle.

Technologies of the self are the practices produced and enabled by wider discourses, such as understandings of health as an individual responsibility achieved through adherence to a healthy lifestyle. This develops both healthy psychology and critical health literature by developing the concept of technologies of the self from an individual to a joint endeavour. But although couples take for granted the interconnectedness of their health practices, multiple norms and discourses create complex conditions of possibility that produce negative as well as affirmative health interactions.

Ideal partners, ideal health citizens: Although joint health behaviours are performative of coupledness, norms of both health and intimate relationships are not always in alignment. Mainstream literature indicated the potential for health advice and influence to create tensions within the relationship (Cole et al., 2013; MacLean et al., 2014; Radley, 1988, 1996), but by drawing on Foucault concept of normativity the present thesis was able to show that such tensions can occur because of the ways in which co-existing, competing, and conflicting norms of health and intimate relationships create multiple discourses, positions, and practices that may be affirmative when aligned, but can produce guilt, blame, anxiety, and fear when they were not.

Expert patients, expert partners: Although health promotion constructs lifestyle change as premised on the rational uptake of simple, scientific, expert knowledge, the findings in this study suggest that people negotiate multiple knowledges in their management of lifestyle change. Participants drew on an intricate mix of experiential, expert, embodied, and affective knowledges in their adoption of neoliberal understandings of healthy lifestyle as risk management. Partners negotiated the differences between and differences in the legitimacy of each other's knowledges, which produced power relations that competed and sometimes conflicted with relationship norms of harmony and autonomy. Understanding health as a joint risk to be managed legitimised partners' surveillance and management of

each other's weight, diet, and exercise. Such surveillance had the potential to violate relationship norms, and to evoke resistance and tension between partners.

Multiple temporalities of lifestyle change: The final key finding was the importance of time in couples' accounts of lifestyle management and change. Despite health information and advice that assumes that a stable state of health is achievable through lifestyle changes that are simple to institute and maintain, partners constructed healthy lifestyle as fluid, effortful, and ultimately short term. Participants negotiated multiple time frames, including the trajectory of their CHD, their diagnosis, treatment, and recovery, as well as their lifespan and other disease and ageing processes. In such talk, participants moved fluidly between these temporal experiences in ways that created multiple subject positions, so that these different temporalities of health could work for and against engagement and non-engagement in lifestyle change, and evoke negative, fatalistic, and also positive emotions.

The findings of this thesis showed how couples face enormous complexity in their management of healthy living and lifestyle change. Healthy lifestyle advice was taken up as a joint project by people in long term relationships, to the extent that their success or lack of success, visible through weight management and adherence to the tenets of a healthy lifestyle, reflects on their relationship. The ideal relationship is a site of appropriate health-related practices, but the norms of health and love are not always in alignment. In their joint technologies of the self, couples negotiated competing and conflicting norms, diverse knowledges and awareness of risk, and multiple temporalities. Couples generally experience health benefits compared with peers not in long-term relationships, but this thesis' findings indicate that couple's joint negotiations of lifestyle advice and change, and the lack of alignment between health and relationship norms produces complex possibilities for both negative and affirmative interactions.

Despite participants' adoption of normative health discourses, there were also occasionally affective transformations of utilitarian, neoliberal understandings of health as a moral, relationship, and civic duty, in ways that could be pessimistic, fearful, and sad, or alternatively joyful and life-affirming. Below I consider how

these findings were enabled by the novel Foucauldian-Deleuzian theoretical and analytic framework to conceptualizing couples' health practices.

10.3 Key findings Research Question 2

Research question 2 asked whether a Foucauldian-Deleuzian theoretical framework could account for and offer new perspectives on the variability and complexity of health behaviour within long-term relationships? I therefore focused on developing and testing a Foucauldian-Deleuzian theoretical framework, to capture the affirmative as well as negative possibilities of health behaviours within intimate relationships, in a way that did not draw on potentially stigmatising categories of dysfunction and deficit.

To address this question, I applied the philosophy of Foucault to conceptualise the normalising forces of health and relationships, and the diffuse, local, and reversible power relations that circulated as couples drew on expert and experiential knowledge to manage health risks and lifestyle change. FDA revealed the ways in which couples adopted and resisted dominant discourses of health and of relationships in their day-to-day health interactions and talk about healthy lifestyle. Foucault's concepts of normalisation, surveillance, and hierarchical judgement provided a framework for understanding the ways in which individuals are regulated and regulate themselves according to norms of health and relationship behaviours. Participants thus made sense of themselves through such norms, which legitimised surveillance of themselves and others. In chapter 6, for example, Joe understood that couples in a good relationship exercised together, and when he and his partner failed to do so, attributed blame to himself for failing to enact relationship ideals.

Making sense of the way participants described their joint health practices, I built on Foucault's notion of 'technologies of the self' (1988, p.18) and Crawford's (2006) insight that valued identities are produced through health practices in the context of neoliberalism and healthism. I argue that the scope of these concepts can be expanded from a focus on individual behaviour to encompass the ways in which couples engage in joint management of lifestyle, and define themselves, their partners, and relationship according to how well they achieved normative health practices. Norms of intimate relationships and of health behaviour are multiple and

not always in alignment, producing diverse and unpredictable outcomes. Relationship norms of acceptance and support for example, can come into conflict with surveillance of a partner's weight or diet, so that to fulfil an imperative of health, an individual might risk a damaging interaction with their partner. Ideals of caring and support mean that they may nonetheless feel anxious about their partner's health if they say or do nothing to encourage a healthier lifestyle. In chapter 8, for example, Dan could not '*put his foot down*' and make Louise take her medication without contravening important relationship norms of equality and autonomy.

Foucault argued that power is diffuse and unstable, and circulates between people in local and reversible patterns (1988a). This understanding was used to analyse the ways in which participants adopted and resisted expert, scientific discourses in their interactions with partners and health-care professionals. The multiple and competing forms of knowledge upon which participants drew mapped onto Foucault's assertion that individuals are always in the position of simultaneously undergoing and exercising power and demonstrated the importance of not conceptualising medicine simply as a totalising power.

Both Foucault and Deleuze developed an ethics that is personal and local, and which requires a mapping of ramifications and consequences for individuals rather than the application of universal moral rules. In this thesis, Foucault's notion of ethics and of local and reversible power relations afforded an exploration of how couples negotiated the consequences of making sense of themselves and their relationships within multiple, competing discourses. In particular, the analysis showed how couples accounted for their attempts to influence and control each other's behaviour in ways that avoided global value judgements that categorised their relationships or them as individuals.

Although couples oriented to normative discourses of health and intimate relationships, and adopted neoliberal understandings of health in their construction of health as achievable through their joint engagement in healthy living, they also resisted and transformed dominant health discourses in their mobilisation of alternative accounts of agency and health. To conceptualise these lines of flight, I turned to the philosophy of Deleuze and Guattari, which provided tools, such as their

concepts of affect and assemblage, to map not only the dynamic and affirmative processes involved in couples' transformation of dominant health discourses, but also to theorise health and love more fully.

Health and love are contested, socioculturally and historically situated constructs which both mainstream and critical approaches struggle to theorise in ways that satisfactorily account for intimate relationships' potential to enhance but also diminish well-being (Davies, 1999; Toyes, 2010). Deleuze and Guattari's (1987) concept of heterogeneous, multiple, dynamic assemblages captures the complexity and mutability of both health and intimate relationships, but Deleuze also offers us Spinoza's definitions of love and health, whose similarity accounts for their affinity. According to Deleuze, health is an affect whereby our capacities, connectedness, and powers of acting are increased, while love is defined as the same enhancement of powers, but attached to an object (Deleuze, 1988; Duff, 2014). These definitions are broad enough to encompass love and health that falls outside of social norms (offering a rethinking of traditional notions of disability, for example), but precise enough that the personal affects can be measured. If a relationship diminishes a person's capacities to act and be in the world, even if it meets normative parameters, such as an abusive marriage, it is not love according to Spinoza and Deleuze's concept. These are simple, but ethical definitions. They encompass the diversity of health and love, which must be judged on their effects rather as inner states or qualities. Spinoza's insight that the same object can agree with us in some respects, but diminish our powers in others (Brown, 2001; Deleuze, 1988), also provides a theoretical framework for ambivalence and heterogeneity in couples' health interactions. Spinoza and Deleuze's conceptualisation of love thus offers a framework for accounting for health psychology research that reports ambivalent evaluations of couple relationship quality (Birmingham et al., 2015), a pattern exemplified in Louise's construction of the medical alert bracelet as both a sign of her husband's love and a stigmatising reminder of her illness.

An affective conceptualisation of health works in a similar way to disrupt ideas of stable, universal categories and states of health which can be achieved and maintained through simple, rational lifestyle decisions and choices (Duff, 2014). Intimate relationships can also be thought of as assemblages, with affective flows

between them and assemblages of health. The resulting multiplicity accounts for the ways that competing and conflicting imperatives of health and intimate relationships may diminish powers and capacities in both or either realm, accounting on an ontological level for the varieties of ways in which couple health interactions may contribute affirmatively or negatively to health practices and outcomes. The related concepts of deterritorialisation and lines of flight offer a conceptualisation of the ways that people resist and transform health discourses, in ways that are affirmative, but also more destructive ways of escaping the heavily coded social space of health and healthy lifestyle.

Combining Foucault's theory of power, knowledge, and normalisation, and Deleuze and Guattari's (1987) concept of material and non-material assemblages, thus provided a framework in this thesis for understanding how lifestyle change, especially in the context of CHD, is contested and contradictory. For example, participants in Study 2 struggled to assess the risks around taking exercise, balancing exercise as a preventative measure against the fear of exercise bringing on a recurrence of their symptoms of CHD. Participants in both studies oriented to health and relationship norms as desirable, yet meeting these norms was often difficult due to the complexity, multiplicity and contradictions within and between discourses of health and relationships, while the material actuality of eating delicious or dispreferred food, or leaving a warm sofa for a run on a rainy night, added an affective, embodied dimension to practices that are usually talked about in terms of cognitive choices and decisions.

Deleuze's theory of affect offers a perspective on pejorative categorisations that arise from neoliberal logic. Drawing on his work, Illouz (2011) argues that pathologisation, categorisation and problematisation are central to therapeutic narratives which hold out the promise of achieving an 'expanding ideal of health' (p.48). Self-help narratives have focused on the formation and maintenance of romantic relationships, both to conform to social and religious norms, and more recently by understandings of romantic relationships as routes to mental and physical wellbeing (Riley, Evans & Robson, forthcoming; Uchino, 2013). Therapeutic narratives can be seen in the participants' identification of pathology either in their lifestyle or their relationship, and the recognition of a goal, which the relationship

itself is called upon to help, fix and heal, either through acceptance or joint technologies of the self. Deleuze (1995) argues that these pathologising narratives are part of regulatory processes. By evoking sad affects and negative emotions, according to Spinoza's philosophy, capacities and power to act are diminished, and Deleuze terms the evocation of such feelings a type of enslavement, and disempowerment.

Below, I discuss how these findings relate to and build upon both mainstream and critical literature.

10.4 Contribution of the findings to health psychology and critical literature

Couples experience concordance for health, but also for risk factors and disease (De Castelnuovo et al., 2009; Kilpi et al., 2015; Meyler et al., 2007). Mainstream health psychology literature proposes that couples' health is influenced by factors arising from the relationship, including four major theoretical approaches described in chapter 3. Variable patterns in benefits to health and inconsistencies in findings in the application of these theories and approaches suggest that other dynamic, interactional processes, as well as wider social factors also contribute to the complexity of couples' health behaviours and functioning. Below I explore how the novel findings of the thesis develop the health psychology and critical literature discussed in chapter 3.

Healthy living as a joint endeavour

Mainstream quantitative and qualitative literature take for granted couples' involvement in each other's health. Social support theory proposes that long-term relationships improve health by creating norms of, and motivation to, comply with protective health behaviours (Durkheim, 1957; Meyler et al., 2007; Thoits, 1983, 2011; Williams & Fredriksen-Goldsen, 2014). Although partner support can facilitate engagement in lifestyle changes, it may also undermine them (Coyne & Smith, 1991; Lett et al., 2005; Molloy et al., 2008; Uchino, 2009), pointing to the complexity of emotional, behavioural and material aspects of couples' health behaviour (Cohen & Janicki-Deverts, 2009; Grewen et al., 2005; Thoits, 2011).

The findings in this thesis correspond with mainstream and critical literature that confirms the salience of health for people in long-term relationships (Radley & Green, 1985; Robles et al., 2014; Seymour-Smith & Wetherell, 2006;). Participants in both studies constructed healthy lifestyle as a joint endeavour, involving joint responsibilities, aspirations, and culpability, so that health and relationships were deeply imbricated in ways that have important ramifications for subjectivity and practice. The analysis in chapter 7 and 8 showed how constructing healthy lifestyle as a joint endeavour develops in the context of illness, so that restoring and maintaining health becomes a deeply interconnected shared experience. A partners' illness affected couples at multiple levels – physical, psychological and emotional,

Mainstream literature demonstrates both positive and negative ramifications of social support in the context of a partner's illness (Franks et al., 2006; Goldsmith et al., 2012; Murray et al., 2006; Robles et al., 2014). The findings of this thesis demonstrate the potential for shared health practices to become sources of conflict and distress, as participants expressed emotions such as fear and anger over their own and partners' failure to maintain a healthy lifestyle. The thesis builds on both mainstream and critical literature by using Foucault and Deleuze locates the variability of health interactions away from stable, deterministic traits and states. Foucault's theory of power enabled a mapping of the power relations that lifestyle change evokes, while conceptualising intimate relationships and health as interconnected assemblages provided a lens through which the intricate patterns in couples' engagement and non-engagement in lifestyle change could be understood.

Inconsistency and change in health-related practices are reported in the literature (Bartley et al., 2004; Tucker & Anders, 2001), and are often assumed to be dysfunctional or suboptimal. For Deleuze and Guattari (1987), however, change is a constant. Affective flows within assemblages accounts for the dynamism and unpredictability of health-related behaviours in a way that is not reductionist or judgmental. Thinking of health as a complex, multiple, dynamic assemblage rather than a stable state that can be achieved and maintained through simple, rational lifestyle decisions and choices, offers an alternative to the linear logic of blame and guilt of neoliberal healthism. Participants were not recounting adherence to clear, achievable lifestyle goals following their diagnosis with CHD, but rather negotiation

of normative, but complex and sometimes conflicting, ways of understanding themselves as responsible health citizens and good romantic partners in the context of their diagnosis and recovery.

Ideal couples, ideal health citizens

What the different health psychology approaches have in common is the assumption that a ‘good’ relationship is one where positive health behaviours will take place (e.g. Smith, Baron, & Grove, 2013). Within the literature that associates relationship quality and satisfaction with health outcomes, support and openness to each other’s needs are designated as positive and associated with benefits, while conflict, hostility and tension are associated with poorer outcomes and some of the markers for CHD (Holt-Lunstad et al., 2008; Fincham & Beach, 1999). Couples’ influence attempts are associated with positive outcomes, but also have the potential to evoke resistance, lower compliance, and conflict, and be perceived as signalling a lack of acceptance and support (Franks et al., 2006; Lewis & Butterfield, 2007; Lewis & Rook, 1999; Murray et al., 2006; Rook et al., 1990; Tucker & Anders, 2007; Umberson, 1987). The logic of this approach is that suboptimal health functioning is indicative of relationship dysfunction, which has the potential to categorise and stigmatise partners and relationships (Law & Urry, 2004). This thesis challenges such assumptions and develops critical literature by using a poststructuralist framework to understand that norms of intimate relationship and of health are not always in alignment. Inconsistency can be seen not as a sign of dysfunction, but as a product of competing and sometimes conflicting norms, positions, and identities as couples negotiate their joint health practices.

The findings of this thesis indicate that couples’ joint technologies of health had to be negotiated alongside parallel, competing, and sometimes conflicting norms of ideal coupledness such as support, acceptance and sympathy. Individualism, autonomy, self-determination, and responsibility are also normative in intimate relationships in late modern times and as well as in health (Giddens, 1992; Rose, 1999), values which have the potential to conflict with couples’ expectations of interdependence. Expectations of care, health and lifestyle management, concerns regarding a loved one’s diet or exercising, and values of equality and autonomy in

relationships all jostled against each other in ways that could produce painful, and sometimes unresolvable tensions. These tensions were evident when participants described failed influence attempts on the other's behaviour or bodies (e.g. shopping or losing weight), which created hurt, anger and frustration.

Gottman & Notarius (2000) argue that emotion remains an important and underdeveloped avenue for future research in the context of intimate relationships and health. This analysis fills a gap in the literature by locating negative and positive affects in the interplay between health and relationship norms, where harmonising or conflicting norms can include or exclude people from valued identities, creating satisfaction or deep anxiety (Davies, 2013). Partners occasionally deterritorialised, or took lines of flight out of normative codings of health and relationships. Building on the work of Davies (2013), who argues that affirmative affects can also be produced through 'changing the norms through which we are recognised' (p.24), the analysis offered empirical examples of how conflicts between norms might be resolved. For example, together Holly and Graham developed a shared acceptance of their lack of control over health and life, which offered them a level of serenity in the face of her serious illness.

Mainstream literature demonstrates both positive and negative ramifications of couples' management of healthy lifestyle (Franks et al., 2006; Goldsmith et al., 2012; Murray et al., 2006; Robles et al., 2014), that are reflected in the findings of this study. This thesis develops this literature in its critical exploration of how social norms of intimate relationships are enfolded into couples' joint health practices, producing affirmative, but also negative experiences since health and relationship values were entwined, but sometimes mutually exclusive.

Expert patients, expert partners

Although the data offered examples of lines of flight from healthism and dominant neoliberal discourses of health as a personal responsibility, couples' talk was still structured by understandings of healthy lifestyle as a means to minimise risk and achieve health (Hansen & Easthope, 2007). Critical health researchers argue that neoliberal constructions of health have potential to elicit negative affects, such as anxiety and fear, even in apparently healthy people (Crawford, 1985, 2006;

Farrimond et al., 2010; Hall et al., 2015; Hansen & Easthope, 2007; Lupton, 1995; Saukko et al., 2012). This thesis builds on their work by conceptualising the co-construction of risk and knowledge within couples' wider account of joint technologies of health in chapter 8.

Participants experienced healthism's 'pedagogy of danger' (Crawford, 2006) on their partner's behalf as well as their own. Couples constructed food and exercise as curative, preventative, and causative of ill-health, but tension could arise as couples drew on multiple, sometimes conflicting, and more or less legitimate forms of knowledge to evaluate and manage risk. Rather than a traditional dichotomy between lay and expert knowledge, participants drew on an intricate mix of expert, experiential, embodied and affective knowledges to support their joint endeavour of lifestyle management. Intimate partners' knowledge was accepted, but also resisted in complex patterns.

Participants also occasionally deterritorialised dominant neoliberal understandings of lifestyle and risk as something an individual can and should control. They asserted other values and ways of being, such as accepting the limits of scientific knowledge, and of personal responsibility, and asserted the value of pleasure, sociability, release from anxiety and control, and fun. This thesis contributes an account of a relational dimension to normative social practices of health, and showed how contradictions and paradoxes that arise for individuals who adopt health as moral, civic and personal duty are multiplied when risks, identities, responsibilities, and practices are negotiated on a partner's as well as one's own behalf.

Qualitative literature relating to couples and health reflect the interconnectedness, dilemmas and conflict, salience of communication, and temporal fluidity found in health psychology research (Cole et al., 2013; Dalteg et al., 2011; Köhler et al., 2016; MacLean et al., 2014; Murphy et al., 2009; Radley & Green 1985, 1986; Radley, 1988, 1995; Sperber et al., 2013). Goldsmith et al. (2012) and Goldsmith and Miller (2014) examine communication strategies that couples use in their negotiation of lifestyle change after CHD. The FDA used in this thesis builds on this qualitative literature in its critical exploration of how couples adopt and resist

wider health discourses, but also how they negotiate the power relations that circulate between partners as they draw on discourses of risk, health, and intimate relationships in their management of lifestyle change.

Crawford (2006) predicted a spiral of anxiety and control in the face of health prevention discourses that evoke danger and fear, that would eventually result in cynicism and disengagement in health imperatives. This response was evident in the data of both studies where participants resisted or challenged the legitimacy of lifestyle advice, but the Deleuzian framework also illuminated more affirmative pathways by which healthism may be resisted, such as a jointly-negotiated letting go of the expectation of control. An active form of acceptance, which was more affirmative than passive fatalism, appeared to offer access to a peace of mind and detachment from anxiety that formed a buffer and thus resistance to neoliberal healthism and the negative affect associated with it.

Multiple temporalities of health

Multiplicity also featured in the final major discourse in the analysis. Time is a rarely considered factor in relation to health behaviours (though see Stronge, 2012 and Radley, 1996 for exceptions), but time formed a distinct discourse in the couples' accounts which they negotiated along with their understandings of health and healthy living as a joint endeavour, and of lifestyle as a form of risk management. Chapter 9 explored how couples drew on multiple, fluid time frames of illness, recovery, and aging. The participants made frequent references to time and drew on past as well as present and future capacities in ways that challenged notions of time as unitary and linear. In their vivid evocations, participants' younger and older selves were made relevant to their present sense-making and formed part of their assemblages of health. For example, Carl's talk oscillated between constructing a healthy and vigorous self that remained stable across time and a self who was experiencing age-related, time-linear decline.

Despite health promotion often presenting health as the outcome of simple, easy choices, the participants in this study constructed health information and advice as varied and contradictory, and not always reducing uncertainty or risk, as when Carl's blood pressure remained high despite his medication and exercise. As Gard &

Wright (2001) argue, neoliberal health discourses problematically assumes the ‘erasure of uncertainty with respect to knowledge about the body’ (p. 537). The supposition of linear causality can thus create an illusion of mastery over health outcomes, whereas this study adds to the mainstream and critical literature in showing that people in ill health negotiate the inevitable uncertainty that arises because medical advice based on population-level probabilities of risk cannot be applied with certainty in individual cases.

The temporalities identified in chapter 9 afforded perspectives that sometimes ratified the value of lifestyle change and management, but sometimes produced a more fatalistic acceptance of aging and death. This could be positive and life affirming, but could also mitigate against lifestyle change by making an over-concern with diet and exercise appear futile or unimportant. Health promotion uses fear-inducing references, and illness inevitably increases awareness of death, but there is a lack of affirmative discourses and practices relating to death (Willig, 2011). Although some participants did adopt fearful discourses of dying, other participants in Study 2 evoked death in more affirmative ways, so that health and illness were constructed as an accepted part of life, as participants took lines of flight away from the anxieties evoked by pedagogies of danger and risk that afforded some peace of mind and detachment from fear.

The analysis presented in chapter 9 contrasts with dominant health discourses that construct health as a stable state, produced through adherence to a healthy lifestyle that is simple to achieve and maintain (Hansen & Easthope, 2007; Lupton, 2014). Within these discourses, time is absent, or only implicitly present in notions of becoming more or less healthy through reversible changes in lifestyle (e.g. Change4Life). Academic literature dealing with patients’ experience also rarely addresses issues of time, tending to reproduce linear views of time and stable states of illness and health (Stronge, 2012). The analysis in this study revealed a temporal multiplicity and fluidity, which participants negotiated alongside more conventional understanding of time as unitary and linear, and which challenged discourses of health and lifestyle change as stable and sustainable. Considering time and the multiplicity of temporalities in participants’ sense-making around healthy lifestyle advice is thus part of the contribution of this thesis to developing more nuanced

understandings of the multiplicity of factors that affect how lifestyle advice is adopted, resisted, and transformed.

Uncertainty was a thread that ran through the discourses of risk and time in chapters 8 and 9 particularly. Uncertainty is usually understood as problematic (Gard & Wright, 2001), but for Massumi (2003), Deleuze's concept of affect encompasses complexity and uncertainty, and offers the basis for hope and activism, since:

Uncertainty can actually be empowering — once you realise that it gives you a margin of manoeuvrability and you focus on that, rather than on projecting success or failure. It gives you the feeling that there is always an opening to experiment, to try and see. This brings a sense of potential to the situation (p.112-113)

Such constructions afforded a mapping of how participants oriented to uncertainty in affirmative as well as negative ways. They sometimes associated uncertainty with increased possibilities and therefore hope, such as when Lily and Eddie used uncertainty in their construction of an optimistic future, as well as to legitimise a hedonistic past. These findings add a relational dimension to Dyke's (2013) argument that, through Deleuze's rejection of pejorative difference and determinism, individual bodies are not constrained to 'contain the abject and pathological and instead engender a hopefulness' (p.150). In drawing on these ideas to facilitate the analysis, the present thesis demonstrates how Deleuze's affirmative philosophy opens up possibilities and new ways of thinking about couples and lifestyle change.

The findings in this thesis correspond with mainstream and critical literature that confirms the salience of health for people in long-term relationships (e.g. Robles et al., 2014). This thesis' findings of multiplicity and fluidity provides a theoretical framework for partner dynamics in mainstream health research, and its critical approach contributes a conceptualisation of heterosexual relationships as sites of control and the reproduction of social order through normative health practices. Neither mainstream nor critical health literature fully capture the affirmative as well as repressive possibilities of intimate relationships (Davies, 1999; Finn, 2005; Toye, 2010), but the Foucauldian-Deleuzian theoretical framework reflected and

encompassed the existing literature, and offered new perspectives on the variability and complexity of health behaviour within long-term relationships.

10.5 Implications.

The findings of this thesis have implications for the provision of health care and lifestyle advice given to patients in long-term relationships. Such advice should take account of partners' joint endeavour, and the responsibility that partners take on for their partner's health as well as their own, doubling the potential for burden, blame, guilt, and harm. Thinking of health and intimate relationships as interconnected assemblages accounts for the complexity, unpredictability, and dynamism of couples' relationship, lifestyle, and health. Even a partner's lack of engagement has the potential to be interpreted as problematic in relation to expectations of health as a joint endeavour.

An implication of health as a joint technology and 'doing health' being performative of coupledness, is that lifestyle advice can be potentially destabilizing for intimate relationships. The recognition of potential harm is a significant finding. Of all the interventions in medicine, lifestyle advice is one of the most common, but one which lacks a secure theoretical or evidence-based foundation (Hansen & Easthope, 2007). Interventions including health information and advice needs to be considered in the light of health discourses and practices as productive not just of individual health identities, but of the ways that couples define themselves and their relationships.

With non-communicable diseases now the leading cause of death worldwide, we need to develop an understanding of the psychology of lifestyle disease – how do patients and their partners and carers manage in the context of illnesses that are attributed to the actions or omissions of the patient? An interchange in the *BMJ* in 2015, relating to whether and how GPs should address the issue of weight with their patients (Shah, 2015; Kirk et al., 2015), highlighted the lack of a universally accepted framework for talking to patients about weight and associated lifestyle advice. Doctors are also subject to the same forces that shape their understandings of lifestyle as lay people (Hansen & Easthope (2007), and without a universally accepted framework for talking to patients, can draw on available neoliberal

discourses that locate responsibility for health, and therefore ill-health, with the patient.

In addition to the lack of a clear theoretical framework for giving lifestyle advice, there is evidence that the moral dimension of neoliberal health discourses contributes to clinician bias against patients who contravene norms of weight and smoking, for example (e.g. Royal College of Surgeons, 2016; Puhl et al., 2015; Webb, 2009). Barry et al. (2015) critique Public Health England's policy of targeting individual behaviour in a programme aimed at people at risk of developing type II diabetes, despite a lack of evidence that such behaviour change interventions are effective at achieving endpoints such as weight loss and improved glycaemic control. Similarly, a range of studies indicate that a moral panic about the threat to the economy and health services provide the conditions of possibility for anti-fat bias (Tomlinson, 2015), the construction of type II diabetes as the 'blame and shame disease' (Brown, Ventura and Mosely, 2013, n.p.), and the potential harm of shame-based appeals in public health campaigns, such as those common in anti-smoking campaigns (Brown-Johnson & Prochaska, 2015). Shame-based advertising can negatively affect those who already have the conditions that public health campaigns warn of such as CHD, type 2 diabetes and lung cancer, and patients who internalise the stigmatising messages have worse psychosocial and physical functioning, exemplified in Erenreichs's statement that, 'victim blaming can weigh on a cancer patient like a second disease' (2009, p.43)

Although doctors and patients draw on the same wider discourses of blame when dealing with diseases associated with lifestyle, there is little research about how physicians and other health care professionals can address such biases (Hill, 2010). The contribution of neoliberal discourses to judgmental, dismissive, or discriminatory care thus creates a significant block to the patient-centred care that is a major goal for the nursing and medical institutions. The Department of Health designates compassion as 'how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care' (Department of Health, 2012, p.13). Patient-centred care is a key principle of NHS care, but concepts such as the expert patient are complex and there is little guidance about what this means in practice or

how it can be achieved (McCarthy, 2016; Mol, 2008). Foucault and Deleuze's notions of knowledge and power provide a framework for thinking through some of these complexities. Patient-centred care that takes account of patient values as well as experiences to provide timely and appropriate medical care. Not only what people want, but when they want it is important, so it is vital to recognising the evolving, dynamics of health and patients' needs and desires (Kocher & Ayanian, 2016; Mol, 2008).

A theoretical framework that overcomes the paradoxes, impasses and judgements inherent in neoliberal discourses of lifestyle and lifestyle disease, and acknowledges the multiple material and non-material forces that produce health and illness could therefore benefit clinicians and their patients and form the ontological basis for ethical, compassionate, patient-centred care. The implications of the present thesis is that a framework underpinned by a Deleuzian ethics' focus on capacities for action is the starting point for developing an accepted framework for talking to patients regarding lifestyle, enabling patients and clinicians to navigate the multiplicity of patient experiences and values.

In this thesis, I have developed a Foucauldian-Deleuzian framework that offers some directions for more compassionate, patient-centred care. The FDA addressed the lack of conceptualisation of power and stigma in understandings of how health care professionals are enmeshed in social discourses of health (Blackburn, Stathi, Keogh, & Eccleston, 2015), which might enable clinicians to understand the barriers and facilitators to patients discussing lifestyle issues with them. Drawing on Deleuze and Guattari and their ontological framework also suggests avenues for developing interventions and programmes/campaigns that do not disempower and stigmatise, and which capture the complexity of individual and couple health behaviours which have been highlighted in this study.

An important finding relates to how the participants jointly negotiated uncertainty, achieving acceptance and serenity in the face of their ill-health, risk, and prognosis. Uncertainty troubles mainstream positivist scientific approaches, but it is something that clinicians and patients have to deal with (McCarthy, 2016), and Deleuze and Guattari's metaphysics, where change is inevitable and integral, not an

abberant occurrence that has to be explained, offers an explanation for unpredictability, change, and unfolding, fluid experiences. Deleuze offers an affirmative philosophy for rethinking and disrupting assumptions and impasses (Davies, 2011), and an acknowledgement of uncertainty. The hopeful possibilities it engenders could prompt initiatives which are inclusive, accepting and freeing for both patients and clinicians, and the people who design public health campaigns. For example, a functional, weight-centred approach to food also crowds out other, more affirmative experiences related to eating such as pleasure and social connectedness. Thus positive, pleasure oriented health promotion might both enable healthier eating and reduce the stigma associated with weight, rather than the logic of blame inherent in morally laden, restrictive prohibitions, whose emphasis on control, and conflation of weight with health is also played out in the stigmatisation and blame of people who do not conform to healthy norms (Vogel & Mol, 2014).

Grosz (2000) explores the value Deleuze's reading of Bergson in conceptualising the future in affirmative but not utopian ways. Current neoliberal health discourses stop short at the moment that health is achieved through responsible consumption and appropriate care of the self. No clear future is offered for people who achieve this ideal and optimised state of being, nor are the inevitable changes to health and capacities at the end of life addressed. These discourses have problematized ill-health, and used it in a 'pedagogy of danger' (Crawford, 2006, p.508) designed to produce particular health behaviours. Fearful discourses of ill-health leave little space for affirmative narratives and understandings of ageing and death. Grosz proposes that the pragmatic philosophical tradition upon which Deleuze draws can facilitate the inspiration and the means to bring about effective action in the world, such as changes to the ways that illness, ageing and death are conceptualised and managed.

10.6 Reflection on the Studies.

I started this thesis with a research question that resonated in my own life. My initial assumptions were that there was an effective way to talk to people about lifestyle which could inspire or enable them to make changes. I expected that some couples would have effective communication strategies, which could be identified

and extrapolated so that clinicians and other carers could adopt them. The problem would be solved. Over this project, I have experienced a significant shift from that stand point. The two examples of reflexivity in the method section (chapter 5) illustrate how the interviews in Study 2 began to challenge my assumptions about intimate relationships and scientific knowledge, prompting me to search for a theoretical framework that would encompass the complexity that the background literature and interviews indicated.

The word-elicitation design in Study 1 produced rich data which highlighted the complexity of couples' health practices, but it was Study 2's longitudinal design that allowed me to explore, both in-depth and across a particular time period, the complexities and fluidity in participants' sense making. This design enabled me to identify and explore changes in participants talk (e.g. Catherine 'letting go' of her anxieties about Henry's greater health in comparison to her own), but it also allowed me to see the constants. Louise's negative affective response to the medical bracelet, for example, remained unchanged.

There were however, a number of limitations to the research. The findings in Study 2 were affected by several factors relating to the sample, recruitment, and the interview design. The first was that participant recruitment took place via a letter of invitation, which potential participants responded to by returning a reply slip, giving me permission and a means of contacting them. In order to meet the requirements of the ethics committee, the letter was quite long, and because of our location, a Welsh version had to be provided on the other side of the sheet. Even though I wrote the letter as clearly as possible, using the Fogg Index to ensure readability, the inevitable wordiness would almost certainly be off-putting to those with lower literacy or with limited English (see Appendix B). In the event, I did not interview anyone from the lowest socioeconomic groups, anyone who appeared to have difficulty reading the participant information sheet, or who had limited English.

This is in line with findings that it is the 'better and better off', the more physically well and socioeconomically secure, who tend take part in most health-related research (Buckley et al., 2007; Hewison & Haines, 2006). Consequently, the voices of more marginalised individuals were not represented in this thesis, and the

details of the particular challenges facing those who must negotiate economic hardship, or difficulties reading prescription bottles and leaflets, for example, were not explored. However, I can only speculate that such intersectionality would exacerbate what is an already complex and challenging life event. CHD affects people from all social classes, which in a health-valuing society takes them to ‘the kingdom of the sick’ (Sontag, 1978), where their knowledge and subjectivities become subjugated to dominant discourses, institutions, and ways of knowing.

The participants also conformed to Hewison and Haines’ (2006) assertion that the more physically well consent to take part in research studies. Participants’ understandings of a typical cardiac patient centred on someone overweight, who smoked, ate an unhealthy diet and who didn’t exercise (Davison, Davey-Smith & Frankel, 1991; Farrimond et al., 2010; Saukko et al., 2012). There was a moral dimension to assumptions that such a person would have brought their illness upon themselves, and most participants differentiated themselves as an unlikely candidate by virtue of their fitness, slimness, and healthy diet. Very few participants attributed their CHD to their lifestyle, or recounted they had been unsuccessful making lifestyle changes. For example, although four of the participants were smokers, all but one had successfully quit, and even the participant who continued to smoke emphasised the small number of cigarettes she smoked. Only one participant in Study 2 problematized his weight, designated himself as fat, and acknowledged his smoking as a factor in his CHD. He oriented to his former lifestyle as morally weighted, repeatedly calling himself a ‘sinner’ and contrasting himself with ‘good boys’. He was from a higher socioeconomic class than the other participants, which may have afforded him other resources to maintain a positive identity despite the ways in which he did not conform to imperatives of health (De Visser, Smith, & McDonnell, 2009).

Since the focus of the letter of invitation was upon couples’ management of lifestyle change, I assume that people whose relationships were more troubled did not choose to take part. Although most couples’ interactions were harmonious, there were indications of how lifestyle change has the potential to violate relationship norms and expectations, and there were instances where participants expressed distress, anger, frustration, guilt, and disappointment. I did not interview anyone who

was managing lifestyle change in the context of a relationship that appeared very unhappy or unstable, or abusive, however, and I can only speculate that lifestyle change would be difficult to manage in this context, given the challenges couples face in apparently stable, happy relationships.

All the participants in the study were heterosexual and most were married, which might limit the transferability of the findings in the context of same sex relationships, later marriage and childbearing, increasing cohabitation, and increasing divorce rates (Berrington & Stone, 2014; ONS, 2014); although there is evidence that similar mental and physical health benefits to living with a partner accrue to married and cohabiting partners (Perelli-Harris & Styrc, 2016). Kurdek (2004) also argues that relationship functioning is similar in gay, lesbian, and heterosexual couples, while Beck and Beck-Gernsheim (1995) suggest that as a result of the de-traditionalisation of relationships, all couples negotiate more contingent and individual ways of being.

Gender is a major focus of mainstream and critical health research (Crawshaw, 2007; Gough, 2009; Markey & Markey, 2011; Seymour-Smith & Wetherell, 2006). In my first analysis of data from both studies, however, other discourses were more salient and clear gendered patterns were not obvious. Tischner and Malson (2012) talk about gender as the big silence in their research into mothers' dieting experiences that they could not fully account for. Although gender is produced through health practices, in this study it is also possible that illness disrupted gendered patterns, as partners of both genders were patients with CHD, unlike studies such as Seymour-Smith and Wetherell's (2006), where gender patterns may have been reinforced by the gender divide of men as patients and women as carers. Calasanti and Bowen (2006) reported that ill-health resulted in greater fluidity in couples' gendered behaviours, with male partners taking responsibility for their wives' dressing and make-up. Conditions such as CHD which affects both men and women offers an opportunity to examine how healthism and postmodern norms of grooming and appearance hail both genders and disrupt traditional patterns of gendered talk and behaviour.

10.7 Future Research.

The findings of this thesis could therefore inform research into how health promotion can better take account of the relational dimension of health behaviour, and of the complexity of peoples embedded, embodied, affective experiences of lifestyle change. In addition to discourses of lifestyle change as oppressive and punitive, participants also tapped into transformative, affirmative experiences of eating and exercising, which could provide the basis for more affirmative and ethical approaches to health promotion. Cataldo, Hunter, Petersen and Shean (2015), for example, reported that affirmative messages about the benefits of smoking cessation were more positively received and considered by older adults, who were inured to discourses of risk, but were surprised in discussions about how they could still improve their health and physical functioning, even if they had been smokers for many years.

According to Foucault's notion of subjugated knowledges, health care professionals are in a position of power in relation to patients (Crawford, 2006; Fox, Ward, & O'Rourke, 2005). In line with research indicating the development of 'lay expertise' (Hall et al., 2015, p.1), participants in these studies drew on multiple epistemologies that disrupt traditional dichotomies of lay and expert knowledge. Research that reveals patients' lay epidemiologies could inform patient-centred care that takes account of patient knowledge and values (Aronson, 2016; Greenhalgh et al., 2015; Saukko et al., 2012). The participants in this study managed uncertainty and risk in affirmative ways, although differing evaluations and understandings of risk also gave rise to anxiety and tension. The findings of this thesis therefore suggest that action research may offer ways of sharing patient and partner expertise to improve couples' experiences of lifestyle change in the aftermath of a diagnosis with CHD.

Although the focus of this study was not upon patient-clinician communication, there were examples of affirmative interactions between health-care professionals, such as the nurse's lifting of Louise's burden of guilt and anxiety over the cause of her CHD, and the empathy Graham inferred from their doctor's acknowledgement of Holly's rationale for her continued smoking. Future research

could explore how health care professionals and patients talk about uncertainty in relation to lifestyle diseases, and how those understandings are then negotiated by patients and their families and friends. Critical perspectives illuminate the power relations that are created in the giving and receiving of apparently simple lifestyle advice. Such research could inform interventions to improve communication and reduce the possibilities for distress and harm that are inherent in discourses of conditions understood to be ‘occasioned by the self’ (Stacey, 1997, p.175). Fox (2002) argues that a model for improved care would involve doctors who “sit presently with our patients and care for them. And allow them to learn, invest and lead in their own recovery, and in the renewable health resource that is community”(p.18). The present study supports these claims and suggests future research on this issue could contribute to the development of practices that avoid the judgemental logic of neoliberal health discourses.

10.8 Concluding Statement.

In this thesis, I have presented two studies, a preliminary exploratory study of healthy people, and an in-depth, longitudinal qualitative study with couples negotiating life style advice after a diagnosis of CHD. This thesis demonstrates considerable dissonance between the complexity of couples’ management of lifestyle change and simplistic, individualistic contemporary health promotion and lifestyle advice. The findings of these studies align with health psychology research that highlighted the importance to health outcomes of couples’ relationships and health interactions (Robles et al., 2014), and also demonstrated couples’ health behaviours, and therefore outcomes, to be complex and dynamic (Uchino et al., 2014). The findings also supported the emphasis critical research places on examining power relations and the discursive context in which couples operate (Finn & Malson, 2010; Seymour-Smith & Wetherell, 2006), and indicated the potential for harm in neoliberal health discourses (Puhl, Peterson, & Luedicke, 2013). The thesis also benefited from Foucault’s recognition of the ways in which the social is folded into the personal through processes of normalisation, and of power as sets of local and reversible relations, using this understanding to illuminate couples’ adoption of and resistance to health discourses in their co-management of lifestyle change.

I also developed the existing literature on the role of relationships in the take up of health practices, showing how health in couples is constructed as a joint endeavour; but within the context of dominant discourses of health as risk, that sit at odds with experiential knowledge of healthy lifestyles as not simple or sustainable. The process ontology of Foucault and Deleuze afforded a mapping of the multiplicity and fluidity of participants' accounts which were full of ephemerality and change. Such complexity is not chaotic and impervious to study and understanding however. Deleuze and Guattari contribute 'essentially inexact yet completely rigorous notions' (Deleuze, 1995, p.29) that can be used to conceptualise the multiplicity, unpredictability, and dynamism of couples' health interactions, and account for the affirmative as well as negative ramifications of lifestyle change for people in long-term relationships. A Foucauldian-Deleuzian approach also provided a theoretical framework to navigate the impasses and contradictions of neoliberal health discourses, and which offer directions for future health care and a significant future programme of research. This metaphysics not only offers an alternative way of understanding human experience, but also the possibility of an affirmative ethics with which to navigate our complex, fluid postmodern world.

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Appendices

Appendix A	Ethics Documentation: Study 1
Appendix B	Ethics Documentation: Study 2
Appendix C	Method Supplementary Information

Appendix A

Ethics Documentation: Study 1

Appendix A1 Participant Information Sheet

Study Information

I am a PhD student in the Psychology department at Aberystwyth University. You are being invited to take part in a research study which will involve one-to-one, individual interviews with men and women about body and body-image issues in long-term relationships.

What is the purpose of the study?

I am interested in how men and women in long-term, romantic relationships talk about body-related issues, in the effects on both partners and on the relationship, and in the ways that people manage these issues in their relationships. This study is not designed to benefit you directly, but it is hoped that the results might help us understand how body image issues affect partners and relationships, and whether we can identify strategies and solutions used by couples which could help improve the way people cope with these issues.

What would be involved for you?

As a person who has lived with your intimate partner for at least three years, you have been asked to take part in an interview with me about your feelings, opinions and experiences of how women's feelings about their bodies may affect their partners and relationship. You will not have to talk directly about your partner or relationship, or about any topic that makes you uncomfortable. There will be an activity in which you choose words that relate to the topic in your experience. You will therefore be able to choose the subject areas you discuss, and decide how much or little you wish to say. The interviewer might ask further questions about a topic you raise, but you will always be able to say if you do not wish to answer or discuss a topic further. The interview will last between 30 and 40 minutes, and will be tape recorded throughout, though you will be able to stop the recording at any time, or ask for all or parts of the recording to be deleted or not included in the study.

Are there any risks to participating?

This study has been designed according to British Psychological Society guidelines, and a relationship counsellor was consulted about the risks of participating in the interviews. It is hoped that taking part in the study will be an interesting and enjoyable experience.

However, it is possible that talking about body image issues in intimate relationships could be painful or distressing for some participants. If that happens, the recording will be stopped, and the interview will only be resumed if you wish, and if you and interviewer agree that it is appropriate. After the interview, if you have any concerns, or the interview has raised issues which you would like to discuss or explore further, a list of resources will be given to you afterwards.

Do I have to take part?

No, taking part in the study is entirely voluntary. You can withdraw from the study at any time before, during, or after the interview. If you wish to see a copy of your transcript, it will be made available to you, and if you decide at any point up to May 2013 that you would like your interview data not to be used, it can be withdrawn from the data set and not used in the final research.

Will my responses be kept confidential?

Your interview will be anonymous, and your name will not appear anywhere on the recording. I will type out the interview, and it will be stored on a password protected computer, and in a locked filing cabinet. It is this transcript which will be used to look for at how intimate partners discuss body image issues and other patterns and ideas. Again, the typescript will also be anonymous, and any identifying details that may appear in the interview (e.g. names, places) will be deleted. When this is completed, I will contact you and offer you the opportunity to read your interview transcript. If there are inaccuracies, I will correct them, and if you would like any part of your interview not to be used, I will delete those sections from the transcript.

The analysis will be written up, and may contain direct quotes from what you have said. However, if this happens, it will still always be anonymous.

The written analysis will be presented as part of a PhD thesis, and may also be presented at conferences, or appear in a journal article. In all of these cases, no names of any participants will ever be used.

Your interview will only be discussed with other researchers, and in any discussions with other researchers, your identity will be similarly protected. I will not disclose the identity of any participants.

What if I have any concerns?

If you have any concerns about the interview or your confidentiality, you are always welcome to contact me (mnr9@aber.ac.uk) or by phone: 01970628610.

Appendix A2**Participant Consent Form**

Participant Consent Form

Title of project: The consequences of women's experiences of embodiment for their intimate partners and relationships

Name of researcher: Martine Robson

Participant Identification Number for this study: _____

Please put your initials in the following boxes to indicate that you agree with the statements below and give your consent to participate in the study.

- 1) I confirm that I have read and understood the information sheet for this study. I have been given the opportunity to consider the information and have had any questions answered satisfactorily.

☐

- 2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

- 3) I understand the steps that will be taken to keep my information anonymous and the limitations to confidentiality have been explained.

☐

- 4) I agree to take part in the above study.

☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

Appendix A3 Participant Debrief Sheet

Debrief Sheet

Thank you very much for your participation. The aim of this research is to find out if how men and women talk about issues connected with body image in long-term intimate relationships. Research suggests that there is a connection between body dissatisfaction and relationship satisfaction, but no study has examined what men and women think and say about their own or a partner's levels of body satisfaction and the effects on their intimate relationships and partners. From these interviews, we hope to fill this gap and gain greater understanding of how the ways people talk about body-related issues affect individuals, their partners, and their intimate relationships.

I hope this has helped to clarify for you the purpose of the study you have just undertaken.

If participation in this study causes you to worry about yourself or your relationship, in addition to contacting your GP, the following is a list of resources which you can contact for help with your concerns:

Student Wellness Centre
(GP, Nurse, or Counsellor Appointments)
Padarn Surgery,
Penglais Rd,
Aberystwyth
Tel: 01970 624545
(Out of hours: 01437 769811)

Relate (relationship and family counselling)
Marine Terrace
Aberystwyth
SY23 2AZ
01267 236737
E-mail: enquiries@relatecymru.org.uk
Website: <http://www.relatecymru.org.uk>

MIND Aberystwyth (advice and support for anyone experiencing mental health problems)
Mill Street
Aberystwyth
SY23 1JB
Tel: 01970 626225
E-mail: info.min@btconnect.com

Samaritans (confidential listening service offering emotional support 24 hours a day)
Tel: 0845 909090

If you have any further questions, or wish to withdraw from the study at any time, please contact me:

Martine Robson
Department of Psychology
Aberystwyth University
01970 628610
mnr9@aber.ac.uk

Your participation is greatly appreciated. Thank you.

Appendix A4 Interview Introduction

Thank you for coming here today and for taking part in this interview.

I would like you to be able to talk about this topic in your own way without my questions influencing how you answer. I have taken words that might be connected with men and women's experiences of bodies and body image in intimate relationships and put them on the table.

I would like you to choose the words that you would like to talk about. You can choose as many or as few as you like. You do not have to talk specifically about your own relationship unless you wish to. You can talk more generally about how you think men and women handle body-related issues in relationships. I might ask you further questions about a word or topic you have chosen, but you do not have to answer or say anything that makes you feel uncomfortable. If you do want to stop, please tell me and we can stop at any time.

If you want to group words together, or arrange them in any order or pattern, please do so, and as part of the study, I will photograph the arrangement at the end of the interview with your consent.

Please let me know when you are ready for the interview and recording to start.

Interview Conclusion

We are coming to the end of our interview. Is there anything you would like to add to what you have already said?

Do you have any questions for me before we finish?

Thank you very much for your participation.

Appendix A5 Interview Schedule

Semi-Structured Interview

The following words will be printed on cards and laid out on the table. Participants will be invited to consider the issue of bodies, body image and appearance in intimate relationships, and to choose words and discuss the experiences, feelings or opinions evoked by those words. If there are words not chosen, they may be used as prompts for further exploration. Blank cards will be provided so that participants can add their own words if they wish. If participants wish or are willing to arrange the cards in any sort of order which represents a category or relationship between the words, they will be encouraged to do so.

men	women	relationship	body
pressure	acceptance	resistance	criticise
behaviour	pressure	reassurance	other people
beauty	love	health	listen
dissatisfaction	weight	happy	confidence
unhappy	talk	media	society
sex	hope	looks	going out

If participants are willing or able to arrange words in a particular pattern in relation to each other and to the relationship, they will be encouraged to do so, and the resulting arrangement photographed at the end of the interview (subject to their consent).

Appendix B

Ethics Documentation: Study 2

Appendix B1 Letter of Invitation to Participate

Dear [Patient name]

You are invited to take part in research being carried out at Aberystwyth University as part of a PhD study. Coronary heart disease (CHD) is the medical name for the disease that causes heart attacks. When a person has had a heart attack, they are advised to take regular exercise, eat a healthy diet and not to smoke. However, these lifestyle changes are not always easy to make. We would like to talk to people who have had a recent heart attack, stent, or bypass surgery or who have been told they have CHD about how they manage these changes. By talking to people with CHD who have lived with a partner for at least two years, we hope to understand how people cope with lifestyle changes and how relationships may affect how people manage. We hope that the information from this study will help health-care workers to offer better advice and support to patients and their partners who are faced with making changes to their lifestyle after a heart attack.

This study has been approved by the consultant cardiologist at [name] Hospital, Dr [name] and by Sister [name], the Cardiac Rehabilitation Team Leader, but will be carried out only by researchers at Aberystwyth University. Sister [name] has sent you this letter because of your recent diagnosis of coronary heart disease, but it is up to you to decide whether to take part or not. Your decision will not affect your medical care in any way, as none of your doctors or nurses will be told whether you decided to take part in the study or not.

If you do decide to take part, I would arrange to meet you in a comfortable, private room at the University or in your own home if you prefer. We are interested in how people cope over time, and so would like to meet with you three times (one meeting a month for three months) to talk about how you are managing with lifestyle changes after your heart attack or surgery. The interviews will take place in English. We are interested in your own experiences and the things you think are important so you will be able to choose the topics you want to talk about.

Each interview will last up to an hour and will be audio recorded. Everything you say will be kept confidential and no names or personal details will appear in the research. The research team will never discuss you with your doctors nor will we ever be given any information about you by your doctors. You will be free to withdraw from the study at any time with no questions asked.

Each person who takes part in this study will be paid £10 after each interview to cover any travel expenses and the time you give in order to take part.

If you would like to find out more about taking part in this study, please return the reply slip in the stamped address envelope provided, or you can contact me, Martine Robson, by telephone: or by email: mnr9@aber.ac.uk with any questions you may have. If you do not wish to take part or receive further information, you do not need to do anything and you will not be contacted again.

I am very grateful to you for considering this.

Yours Sincerely,

Martine Robson

Appendix B2 Participant Reply Form

PROJECT TITLE: Management of lifestyle changes following a first diagnosis with coronary heart disease

Please complete this reply slip if you would like to learn more about taking part in this study. A member of the research team will then contact you to tell you about the study, answer any questions you may have, and arrange to meet with you if you think you would like to take part.

You are **not** agreeing to take part in the research by filling in this form. You will be able to decide that you do not want to take part at any time after talking to the researcher.

I do not wish to participate in this study or be contacted about it ☐

If you have ticked this box, you do not need to fill in or send the form. You will not be contacted again.

Only complete the section below if you wish to know more about taking part in the research and are happy for the researcher to contact you using either your telephone number, postal address or email.

Name:

Postal Address:

Telephone number:

E-mail address (if applicable)

Please return this reply slip in the pre-paid envelope provided.

If you have any questions, please contact: [Researcher Contact Details]

Appendix B3 Participant Information Sheet

Study Information

You are being invited to take part in a research study that is being carried out by Martine Robson, a PhD student at Aberystwyth University. Coronary heart disease (CHD) is the medical name for the disease that causes heart attacks. When a person has had a heart attack, they are advised to take regular exercise, eat a healthy diet and not to smoke. However, these lifestyle changes are not always easy to make. To find out more about how people in long-term relationships manage these lifestyle changes, we would like to interview couples who have lived together for at least two years and where one partner has had a recent heart attack, stent, or bypass surgery or been told they have CHD.

This study has been discussed with and approved by the consultant cardiologist at [Name] Hospital, Dr [Name], and the Cardiac Rehabilitation Team Leader, but it is being carried out by researchers at Aberystwyth University and not by any staff at [Name] Hospital. Only Sister [Name] is aware of who was sent a letter of invitation. Your decision to take part or not will not affect your medical care in any way, as none of your doctors or nurses will ever be told of your decision.

What is the purpose of the study?

We hope that the results will help us understand how couples talk about and cope with lifestyle changes after they or a partner has been told they have CHD, had a heart attack, stent or cardiac surgery. Knowing more about how they manage could help health-care workers to offer better advice and support to people with CHD and their partners.

What would be involved for you?

We are interested in how people cope with these changes over time, and so we would like to meet with you three times (one interview a month for three months). If you decide that you would like to take part, you could choose to be interviewed either in a

private room at Aberystwyth University, or in your own home if you prefer. The interviews will take place in English.

You would be asked a general question about your experiences of lifestyle changes after being told that you or your partner has CHD. You would be free to choose the topics you want to discuss, and decide how much or little you want to say. The interviewer might ask more questions about a topic you raise, but you would always be able to say if you did not wish to answer or discuss anything further.

The interview would last between 40 and 60 minutes, and be audio-recorded throughout. You would be able to stop the recording at any time, or ask for all or parts of the recording to be deleted or not included in the study. You can do this at any time up to the end of January 2015 without giving a reason by asking me in person or contacting me by letter, phone or email.

You would be free to decide not to take part at any time without having to give a reason. If this happened, any interviews that had already taken place would not be used in the study unless you agreed that you were happy for them to be used.

The recording would be typed up and all names, place names and any other details that might allow you to be recognised would be changed. The typed-up copy of the interview would be used to look at the ways that couples and people not in a long-term relationship talk about and manage lifestyle changes after a diagnosis of CHD. The results of the study will be written up into a short report which I would send you if you wished to see it. No names will appear in this report. The results will also be written up in a longer report as part of a PhD study at Aberystwyth University, and may be presented at conferences or published in a scientific journal. If you wished to, you could discuss the results of the study with me, or contact me at any time with any questions.

Each person who takes part will be given £10 per interview to cover any transport costs and time, and any inconvenience that taking part in the study may cause. If at any time you decided you do not want to take part any more, you would keep any payments already given.

Are there any risks to participating?

This study has been designed according to National Health Service and British Psychological Society ethical guidelines to protect the people who take part. This study was also discussed with a heart doctor and a relationship counsellor to get advice about the following risks:

It is possible that talking about your or your partner's recent illness could be upsetting or cause you to worry about your own or partner's health. If you did get upset for any reason, the recording would be stopped, and the interview would only carry on if you wanted to, and if you and the interviewer agreed that it should. We would talk about your wishes and needs and you would be given information about where you could go for help or support with your concerns, such as the Cardiology Team at [Name] Hospital, your GP, or a carer support organisation. If you express concerns about your medical care, these will be treated with strict confidentiality, and information will be given about contacting your GP, the Cardiology Team, or if you wished to make a complaint, the Health Board's complaints procedure.

Serious illness can put pressure on both partners in a relationship, and although you do not have to talk about anything you do not want to, taking part in this study might cause you to worry about your relationship. Again, if this caused you to feel upset, or you wanted to stop the interview, the recording would be stopped immediately, and all or part of the recording could be deleted as you wish. We would talk through your concerns and needs, and you would be given information about where you could go for support, such as relationship counselling services.

After the interview, all participants will be given an information sheet with a list of contact details for places to go for help if you have any worries about your health, your relationship or how you are coping after your or your partner's illness.

Will my responses be kept confidential?

Yes, your confidentiality will be protected in the following ways:

No one except the main researcher, Martine Robson, will ever know the names of the people who take part in the study and she will be the only person who hears the recordings of the interviews.

Your doctors and nurses will not be told whether you decided to take part or not.

The only place your name would appear is on the consent form and this would be kept in a locked filing cabinet in Aberystwyth University. It would be number coded, and this number would be used on your interview recording instead of your name. If you decided to withdraw from the study, the consent form would be used to find the code number so your recording could be removed from the study.

After the interviews, the recordings would be stored on a password-protected computer at Aberystwyth University. It would not contain your name or any personal details. Instead of your name, a number code would be used. The interview would be typed up and any personal details that may appear in the interview, such as names and places, would be changed. You could contact me at any time if you wanted to see copy of the typed-up interview.

The results of the study will be written up into a short report and a longer written report will be presented as part of a PhD, and may also be presented at conferences, or appear in a journal article. In all of these cases, no names of any participants will ever be used. They may contain direct quotes from what you have said. However, if this happens, no one's real name will ever be used with and personal details would be changed to protect your privacy.

In exceptional circumstances, if you said something that suggests you or another person may be at risk of harm, the interviewer may break confidentiality to protect you or the other person in accordance with the British Psychological Society's 2009 guidelines.

Do I have to take part?

No, you are free to choose whether you want to take part or not. We only want you to take part if you are completely happy to do so and if you feel that all your questions have been answered.

Please remember that you can say no to taking part at any time before, during or after the study, up to the end of January, 2015. Even If you do say yes, you can change your mind at any time and no one will ask you why. You do not have to make a decision today. You can take up to four weeks to decide if you would like to take part and contact me by letter, phone or email to let me know.

What if I have any concerns?

If you have any concerns about the interviews or your confidentiality, you are always welcome to contact Martine Robson by email: mnr9@aber.ac.uk , phone: 01970628610.

If you want to speak to someone who is not part of the research team about this study or taking part in research, you can contact [Name], Hywel Dda Health Board's Research and Development Manager, by email: [Contact Details].

Appendix B4 Participant Consent Form

Title of project: Management of lifestyle changes following a diagnosis of coronary heart disease

Name of researcher: Martine Robson **Participant Identification Number for this study:**

Please put your initials in the following boxes if you agree with the statements below and give your consent to take part in the study:

- 1) I confirm that I have read and understood the information sheet (Version 2, 01/14) for this study. I have been given the opportunity to consider the information and have had any questions answered satisfactorily.

☐

- 2) I understand that my participation is voluntary and that I am free to withdraw up to January 2015, without giving any reason.

☐

- 3) I give my consent for the interviews to be audio recorded.

☐

- 4) I understand the steps that will be taken to keep my information anonymous and the limitations to confidentiality have been explained.

☐

- 5) I agree to take part in the above study.

☐

Name of participant

Date

Signature

Name of researcher

Date

Signature

Appendix B5 Debrief Sheet

Thank you very much for taking part in this study.

The purpose of the study is to find out how people talk about and manage the changes to their exercise, eating and smoking habits that doctors advise after they been told they have coronary heart disease. We are looking at the things that may help or make it more difficult for people to follow healthy lifestyle advice.

We hope that the information in your interviews will help us understand how health care workers can offer more support to people who are faced with making changes to their lifestyle and health after a heart attack.

I hope that this has been an interesting and positive experience, but if taking part in this study has caused you to worry about your health, as well as suggesting that you contact your GP, I have listed some places where you can go for help with your concerns:

If you are worried about your health or about how you are coping after your heart attack, stent or cardiac surgery, please contact Dr [Name] or Nurse [Name]:

Name	Name
Cardiology Department	Cardiac Rehabilitation Nurse Specialist/Team Leader
Address	Address

This Support Service provides practical and emotional support for families and carers:

British Red Cross Ceredigion Carer Support Service

Unit 20, Parc Teifi
Cardigan SA43 1EW
01239 615945

If you have any further concerns, or wish to withdraw from the study at any time, please contact me:

Martine Robson

Department of Psychology
Aberystwyth University
SY23 3UX
Tel: 01970 628610
Email: mnr9@aber.ac.uk

Appendix C

Method: Supplementary Information

Appendix C1 Sample Transcript

Transcript of interview with Joe (mid 20s, agricultural worker, married with children) Study 1

Int: okay so um as you look at these are there any words that kind of stand out for you at all when you think about you know body image and relationships and

Joe: fat

Int: yeah

Joe: (.) yeah (laughs) I know it sounds bad but um we are both always uh conscious of getting fat and we both always say would we would we leave each other if [(laughs) we got fat

Int: [(laughs)

Joe: it's true 'cause well I tell her I wouldn't leave her I'd just straighten her out a bit and I'd expect her to say the same about me if I was starting to

Int: right

Joe: be like my uncle (name) for example just let himself go completely and uh be a disastrous mess 'cause you've got to have some pride in yourself don't you

Int: right so you wouldn't be offended if she said oh [you're putting on weight

Joe: [I wouldn't be offended no
but then I'd expect her not to be offended if I said in fact um (laughs) that's that's
in theory hasn't happened yet so (laughs) (inaudible)]

Int: (laughs) so so you you're saying it's it's a sign that people are letting themselves go and you don't have pride is it is it more about the health or is it about appearance or is it about

Joe: um bit of both really 'cause I think it's (.) um self esteem (.) and uh people say people uh in general I fat people bubbly and all the rest of it but in fact I've got a few of my family wh behind closed doors they're not

Int: mm

Joe: they they're actually a depressed bunch (laughs) [which

Int: [really

Joe: does actually affect them and uh why why get to that extreme when you've got someone telling you you know early on to do something about it you know

Int: so do you think your lifestyle puts you at risk of that do you think it [it's

Joe: [yes

Int: in what way [would you

Joe: [because I'm I'm terrible on what I eat

Int: really

Joe: yeah I'm hopeless everything sweet like today I've already had two bars of chocolate this morning before breakfast

Int: really

Joe: I and and at night I have to I bring a load of junk home

Int: mm

Joe: I know I know I'm lucky at the moment 'cause I'm active whereas (name) although she's active looking after children she's not as physically active so she finds it hard she (phone rings and tape paused) yes so I'm probably the worst one for example when I was in (country)

Int: mm

Joe: she (name) lost a lot of weight and she was v really good it was only when I came back that (laughs) she put weight on because my my I don't go to the gym I can't be bothered with the gym

Int: right

Joe: I've never had to go to the gym maybe one day I'll have to but um uh what I bring home she it's not really fair it's not really fair

Int: right so she

Joe: she'll eat what I'm having you see

Int: mm

Joe: and she loves chocolate and she loves crisps and just like anyone else but because of the way I I just keep buying it

Int: mm

- Joe: (laughs) so so really that that's when we've both got to work together really I've got to do it buy it and keep it in the car
- Int: mm
- Joe: or stop it altogether really
- Int: and have you tried any of those things yet or do you just
- Joe: yeah we try after a weekend off weekend off is when we say we can do whatever but um it always drags on [(laughs)
- Int: [(laughs)
- Joe: to the next week I've got lagers in the fridge from the weekend off and I'll keep drinking them and that sort of thing
- Int: mm
- Joe: but um I I'm pretty confident we always say that we're going to one day go exercising and all the rest of it I just don't know how how couples do that we want to do that we just can't (laughs)
- Int: just [time
- Joe: [time is well I'm never never in before half past seven and I'm not going out again just to just to do that (.) so yeah I do see it as sort of my fault uh like (name's) weight weight was up and down as my fault really
- Int: you you you're a bad influence
- Joe: yeah I'm a bad influence (laughs) yeah mm do you are you asking me questions or
- Int: yeah no just any any of the other words that

Appendix C2 Sample Research Diary and Reflection

Diary: Thursday 11th September 2014

Alun – Interview 2

I found this interview difficult to begin with. A was very quiet, pausing more and giving shorter answers than last interview. I felt as though I was bombarding him with questions. I tried to let the pauses stretch out, and when I did, just when I thought the interview might be over and he'd finished, he would say something else. Things settled down when he started to talk about work. As was clear in the first interview, he strongly attributes his MI to stress at work, and has gone back at a lower grade. This was difficult but he felt his counselling sessions had helped him to step back from other people's problems (he's supposed to say 'that's not my monkey' – image of him carrying lots of monkeys around on his back). He laughed a bit about it but seemed to find it useful and had even said it to some people at work. The most support seemed to come from his friend who had had a similar grade of job and who was also coming back on a lower grade after a health scare. They'd done a bit of planning together about how they were going to cope and A seemed to think that together they would manage issues and stress. He laughed a lot talking about his friend and was more animated than last time.

Talked more after the interview this time (about 15 mins) about wanting to stop the counselling sessions. He'd had some useful practical advice about saying no to other people's problems, but did not want 'deeper' levels dragged up and said he doubted that people can 'change their nature'. He said that he saw his MI as having been a good thing – forcing him to take stock of work etc, but the 'only niggling thing' is the open ended nature of his illness because his arteries weren't suitable for stenting he worried he was likely to have another event – almost envious of people with stents and talked about the one-upmanship of people comparing experiences. He expressed his irritation/discomfort again about the nurse/doctor? (first time he said it was a doctor, this time he said nurse) who told him at the tertiary hospital that his MI was caused by his smoking. He talked about the emphasis on lifestyle causes when he is sure his CHD was caused by genetics

and mainly work stress. He sounded more positive during this talk than at the beginning of the interview when I thought he'd seemed a bit 'low', but compared with last time, expressed a lot less anxiety about going back to work, future health, money. He said he'd seen the value of being more open and receiving and giving help and support.

Reflection

The issue of leaving silences is one that I had read about (Kvale and Brinkmann, 2009) but it is much more difficult to do in practice. A seemed quiet and low in mood, so it felt as though I was being intrusive, both in the number of questions I asked and feeling as if I was potentially pushing him to say more than he had the energy for. When I was able to control the impulse to fill a silence, he always started talking again. I need to remember this if/when this happens again. It would be more effective also because it was hard to formulate questions - from the beginning, A had been dismissive of issues relating to diet and exercise, attributing his CHD almost entirely to stress at work. As he talked, he would say something I construed as negative (i.e. that he wanted to end the counselling), but then he would go on to talk about it in a much more positive way, like being able to put the counsellor's advice into practice. I need to hold off evaluating what is said and be a bit calmer about waiting for the interview to unfold. This push-pull, positive & negative is a pattern in the data I think, as R's story about the doctor shows (Richard had said his doctor had shouted at him for not losing weight and my immediate response was to think that was outrageous, (and unempathic as R described the doctor as overweight). Fortunately I didn't say anything, because in the following interview, he said that he respected the doctor and felt that because of his own weight, the doctor understood R's situation and knew what he was talking about). Similarly here, I assumed that A felt negatively towards the therapist since he didn't want to go anymore, but I had to revise this evaluation when he added more layers to his account. Certainly, I'm seeing nuances as participants weigh up the cost benefit analyses of their treatment/lifestyle change.

It's easy to feel empathy for the participants and sometimes difficult not to feel judgemental about the care they do or don't receive, but I've got to remember to

withhold totalising judgement on the people in their stories too. This is an advantage to the longitudinal interviews – I’m seeing things as fluid that I might take as the final word on the matter if I’d only heard one reference to them, rather than this revisiting and reevaluation.

He didn’t talk much about lifestyle, and I sometimes felt anxious about this, but after my experience with P (asking the nurse if his diet had caused his CHD!), I didn’t want to push an emphasis on lifestyle. I’m glad I didn’t, because it was clearer after the interview that lifestyle to A means smoking, and the ‘he’s a naughty boy he’s a smoker’ comment from a health care provider when he was in hospital still distresses him. It feels like a bit of a minefield, and the interviews themselves are quite emotional for me too – responding to the emotions in A and those evoked by his stories, as well as what is going on for me as a researcher, feeling anxious and ruminating on things I say and don’t say. I wonder if this is just because I’m an inexperienced interviewer. Most papers don’t say much about the interviewer’s feelings.

As the data accumulates, I’m beginning to see that there might be scope for other analyses. I won’t fit everything into the couple focus and have to remind myself how little of the data made it into the analysis of Study 1. This makes me feel more relaxed about the directions the participants take the interviews in.